

1 UNITED STATES DISTRICT COURT

2 NORTHERN DISTRICT OF OHIO

3 EASTERN DIVISION

4 * * *

5
6 IN RE:

7 NATIONAL PRESCRIPTION MDL 2804

8 OPIATE LITIGATION Case No. 1:17-md-2804

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10 * * *

11 Deposition of ERIC A. GRIFFIN,
12 Witness herein, called by the Defendants for
13 cross-examination pursuant to the Rules of Civil
14 Procedure, taken before me, Christine Gallagher,
15 a Notary Public and Registered Professional
16 Reporter in and for the State of Ohio, at the
17 Sheraton Columbus at Capitol Square, 75 East
18 State Street, Judicial Board Room, Columbus,
19 Ohio, on Wednesday, the 23rd day of January,
20 2019, at 8:48 a.m.

21 * * *

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10 EXHIBITS MARKED

11	(Thereupon, Defendants' Exhibit	21
12	Number 1, Notice of Videotape 30(b)(6)	
13	Deposition of the State of Ohio Board	
14	of Pharmacy, was marked for purposes	
15	of identification.)	
16	(Thereupon, Defendants' Exhibit	24
17	Number 2, Subpoena to testify at a	
18	Deposition in a Civil Action, was	
19	marked for purposes of identification.)	
20	(Thereupon, Defendants' Exhibit	44
21	Number 3, Letter Dated September 27,	
22	2006 from the U.S. Department of	
23	Justice Drug Enforcement	
24	Administration, was marked for	
25	purposes of identification.)	

1 (Thereupon, Defendants' Exhibit 91
2 Number 4, State of Ohio Board of
3 Pharmacy Complaint Form, was marked
4 for purposes of identification.)
5 (Thereupon, Defendants' Exhibit 115
6 Number 5, Document: Ohio Governor's
7 Office Force Pharmacy Firing, was
8 marked for purposes of identification.)
9 (Thereupon, Defendants' Exhibit 140
10 Number 6, Ohio Prescription Drug Abuse
11 Task Force Initial Report Dated May
12 17, 2010, was marked for purposes of
13 identification.)
14 (Thereupon, Defendants' Exhibit 154
15 Number 7, Settlement Agreement with
16 the State Board of Pharmacy, Docket
17 No. D-990726-009, was marked for
18 purposes of identification.)
19 (Thereupon, Defendants' Exhibit 158
20 Number 8, Order of the State Board of
21 Pharmacy vs. Charles A. Gilford,
22 Docket No. 6-65-2, was marked for
23 purposes of identification.)
24
25

1 (Thereupon, Defendants' Exhibit 161
2 Number 9, Order of the State Board of
3 Pharmacy vs. Henry E. Agin, R.Ph.,
4 Docket No. 6-88-1, was marked for
5 purposes of identification.)

6 (Thereupon, Defendants' Exhibit 167
7 Number 10, Minutes of the June 9-10,
8 2014 Meeting of the Ohio State Board
9 of Pharmacy, was marked for purposes
10 of identification.)

11 (Thereupon, Defendants' Exhibit 174
12 Number 11, Minutes of the September
13 13-15, 2010 Meeting of the Ohio State
14 Board of Pharmacy, was marked for
15 purposes of identification.)

16 (Thereupon, Defendants' Exhibit 177
17 Number 12, Minutes of the December
18 1-3, 2014 Meeting of the Ohio State
19 Board of Pharmacy, was marked for
20 purposes of identification.)

21 (Thereupon, Defendants' Exhibit 183
22 Number 13, Fax Dated April 21, 2016
23 with attached Suspicious Order Report,
24 was marked for purposes of
25 identification.)

1 (Thereupon, Defendants' Exhibit 187
2 Number 14, State of Ohio Board of
3 Pharmacy 3rd Quarter 2017 - Rule
4 Update, was marked for purposes of
5 identification.)

6 (Thereupon, Defendants' Exhibit 192
7 Number 15, Minutes of the December
8 8-9, 2008 Meeting of the Ohio State
9 Board of Pharmacy, was marked for
10 purposes of identification.)

11 (Thereupon, Defendants' Exhibit 203
12 Number 16, Ohio State Board of
13 Pharmacy Newsletter Dated November
14 2014, was marked for purposes of
15 identification.)

16 (Thereupon, Defendants' Exhibit 224
17 Number 17, Ohio State Board of
18 Pharmacy Newsletter Dated May 2010,
19 was marked for purposes of
20 identification.)

21 (Thereupon, Defendants' Exhibit 228
22 Number 18, Ohio State Board of
23 Pharmacy Newsletter Dated May 2011,
24 was marked for purposes of
25 identification.)

1 (Thereupon, Defendants' Exhibit 242
2 Number 19, Settlement Agreement with
3 the State Board of Pharmacy in the
4 matter of Cardinal Health 110, Inc.,
5 was marked for purposes of
6 identification.)

7 (Thereupon, Defendants' Exhibit 264
8 Number 20, Ohio Automated Rx Reporting
9 System 2017 Annual Report, was marked
10 for purposes of identification.)
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1 APPEARANCES:

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ALSO PRESENT:

Vincent Glynn, Covington & Burling
Robert L. Miller, Videographer

1 THE VIDEOGRAPHER: We're on the
2 record.

3 THE NOTARY: If you'll raise your
4 right hand, please, to be sworn.

5 ERIC A. GRIFFIN
6 of lawful age, Witness herein, having been first
7 duly cautioned and sworn, as hereinafter
8 certified, was examined and said as follows:

9 CROSS-EXAMINATION

10 BY MS. BROWNE:

11 Q. Good morning, Mr. Griffin. As we
12 met before the deposition, my name is Maureen
13 Browne, and I represent McKesson Corporation in
14 this litigation.

15 Could you state your name for the
16 record, please?

17 A. Eric A. Griffin.

18 Q. Spell your last name, please.

19 A. G-R-I-F-F-I-N.

20 Q. Are you currently employed,
21 Mr. Griffin?

22 A. I am.

23 Q. And where is at?

24 A. At the Ohio State Board of
25 Pharmacy.

1 Q. Have you been deposed before?

2 A. No.

3 Q. So let's go over a few ground
4 rules so we're operating from the same play
5 book. I'll be asking you a series of questions
6 today which will require you to provide an oral
7 response.

8 A. Okay.

9 Q. If at any time you don't
10 understand a question I've asked, please ask me
11 to repeat it.

12 A. Okay.

13 Q. If at any time you need a break,
14 you can ask for one. We generally will take a
15 break every hour, but you are -- if you need a
16 break before that, certainly be free to ask.

17 A. Okay.

18 Q. I would just mention that if you
19 do need a break and there's a question pending,
20 we complete that question before we go off the
21 record.

22 A. Okay.

23 Q. Is there any reason that you are
24 unable today to give your full, complete and
25 honest testimony?

1 A. No, ma'am.

2 Q. You're not under the influence of
3 any drugs or alcohol?

4 A. No, ma'am.

5 Q. Also, because of the way the
6 record works, even if you can anticipate what
7 I'm asking, you'll need to wait for me to
8 finish my question before you start to speak,
9 and I'll do my best to wait until you complete
10 your answer before I begin the next question.
11 Fair?

12 A. Absolutely.

13 Q. What, if anything, did you do to
14 prepare for the deposition today?

15 A. I prepped with in-house counsel, I
16 prepped with our Assistant Attorney General, I
17 also spoke to other members of our staff.

18 Q. How many times did you -- well,
19 let me ask you this: When you say you prepped
20 with in-house counsel, is that Ms. Dehner?

21 A. Yes.

22 Q. Anybody else?

23 A. Also in-house counsel Joe Koltak.

24 Q. How many times did you meet with
25 in-house counsel?

1 A. Two for those, but then also, in
2 talking to other staff members, two additional
3 times.

4 Q. Who were the other staff members
5 with whom you met?

6 A. Cameron McNamee and Steve
7 Schierholt.

8 Q. What is Mr. McNamee's --
9 Mr.?

10 A. Yes, ma'am.

11 Q. -- Mr. McNamee's position?

12 A. Director of communication.

13 Q. And what is Mr. Schierholt's
14 position?

15 A. Executive director.

16 Q. Did you meet with them at the same
17 time or separately?

18 A. Separately.

19 Q. What did you discuss with
20 Mr. McNamara (sic)?

21 A. Some of the questions that may be
22 asked and reviewed some of the subpoena
23 information, the types of questions that were
24 in the subpoena.

25 Q. What did you discuss with

1 Mr. Schierholt?

2 A. The same, questions that were
3 related to the subpoena and questions that I
4 could anticipate would be asked today.

5 Q. How long did you meet with
6 Mr. McNamara (sic)?

7 A. It's McNamee.

8 Q. I'm sorry.

9 A. That's okay.

10 Q. I beg your pardon. I've got my
11 colleague down at the end of the table on my
12 mind.

13 A. No problem. Once.

14 Q. For about how long?

15 A. Maybe an hour.

16 Q. What about your meeting with
17 Mr. Schierholt, how many times did you meet
18 with him?

19 A. One time.

20 Q. For how long?

21 A. Maybe an hour or less.

22 Q. You mentioned that you met with
23 Ms. Dehner and Mr. Koltak --

24 A. Yes.

25 Q. -- twice?

1 A. Yes, ma'am.

2 Q. For how long?

3 A. Total for both meetings or each
4 meeting?

5 Q. Total is fine.

6 A. Maybe two to three hours.

7 Q. You mentioned that you also met
8 with an individual from the Attorney General's
9 office, correct?

10 A. Yes, ma'am.

11 Q. Is that Mr. Wakley?

12 A. Yes.

13 Q. How long did you meet with
14 Mr. Wakley?

15 A. I met with him also at the same
16 time that I met with in-house counsel Dehner
17 and Koltak, so two to three hours.

18 Q. Other than the meetings with
19 in-house counsel, the Attorney General's office
20 and Mr. McNamee and Mr. Schierholt, did you do
21 anything else to prepare for the deposition?

22 A. Just reviewed the questions, some
23 of our rules, our laws, guidance documents,
24 some different policies and procedures.

25 Q. When you say guidance documents,

1 what do you mean?

2 A. Guidance documents that we publish
3 on our website for our licensees.

4 Q. Other than rules, laws, guidance
5 documents, policies and procedures, did you
6 review any other documentation in preparation
7 for the deposition?

8 A. The Ohio Administrative Code and
9 Ohio Revised Code. In addition, correspondence
10 from McKesson reference our latest rule
11 proposal.

12 Q. Other than the meetings with
13 counsel, the review of the documents we've just
14 discussed, did you do anything else to prepare
15 for the deposition?

16 A. I did review some case statistics,
17 some suspicious order statistics, prior
18 convictions. That would be it.

19 Q. Where did the case statistics come
20 from that you reviewed?

21 A. That would come from our matrix
22 system, which is our records management system.

23 Q. Are any of those records public?

24 A. No.

25 Q. You mentioned that you also

1 reviewed suspicious order statistics; is that
2 right?

3 A. Yes.

4 Q. How did you access suspicious
5 order statistics?

6 A. They're in an Excel spreadsheet.

7 Q. Did you have to create that Excel
8 spreadsheet or does it exist in Excel's format?

9 A. It exists in Excel format.

10 Q. What was the time period that you
11 reviewed for suspicious order statistics?

12 A. Last three years.

13 Q. 2015 to 2018?

14 A. Yes.

15 Q. The --

16 A. I take that back, '17. '17 and
17 '18 and '19.

18 Q. So 2017 through the present of
19 '19?

20 A. To present, yep.

21 Q. Okay. The case statistics that
22 you reviewed, what was the date range for that
23 -- those documents?

24 A. The last five years.

25 Q. So that's 2014 to present, or

1 2013?

2 A. 2014 to the present.

3 MR. EMCH: Might I ask the witness
4 to speak a little louder?

5 THE WITNESS: Sure, absolutely.

6 BY MS. BROWNE:

7 Q. You also mentioned that you
8 reviewed prior conviction information, correct?

9 A. Correct.

10 Q. Where does that information
11 reside?

12 A. It would also be in matrix where
13 all of our case information is kept.

14 Q. And for what period of time did
15 you review the convictions?

16 A. Same period of time, five years.

17 Q. So about 2014 to the present?

18 A. Yes, ma'am.

19 Q. The conviction information is
20 public, right?

21 A. Correct.

22 Q. And how would a member of the
23 public access that information?

24 A. Through the county clerk's office,
25 Clerk of Courts office in the jurisdiction in

1 which a conviction took place.

2 Q. The conviction information that
3 you reviewed is not available through a
4 website?

5 A. It is.

6 Q. Is it available through the Board
7 of Pharmacy website?

8 A. No, no, it would be through the
9 independent county Clerk of Courts or whatever
10 jurisdiction that the conviction had taken
11 place in.

12 Q. What is the nature of the
13 information that the Board of Pharmacy
14 maintains regarding convictions? In other
15 words, how is that different than what one
16 could access through, you know, the clerk's
17 office of the jurisdiction where the conviction
18 took place?

19 A. What I was looking for
20 specifically was those -- the judgment entries,
21 the final disposition on a case or an
22 investigation.

23 Q. So the Board of Pharmacy maintains
24 actual investigation files related to those
25 convictions?

1 A. Yes, ma'am.

2 Q. And those investigation files are
3 not public?

4 A. Correct.

5 Q. Did you review investigation files
6 or just statistical information about
7 convictions?

8 A. No, specific case files I looked
9 at.

10 Q. About how many?

11 A. A couple dozen, I would say.

12 Q. Does the couple dozen conviction
13 investigation files that you reviewed represent
14 the total number of convictions during that
15 period of time?

16 A. No, ma'am.

17 Q. How did you choose which
18 investigative files to review?

19 A. I was looking for investigative
20 files related to Cuyahoga and Summit County.

21 Q. And the approximately two dozen
22 files that you looked through related to prior
23 convictions, do those represent the entirety of
24 the convictions in Cuyahoga and Summit for that
25 period, 2014 to the present?

1 A. No, ma'am.

2 Q. What specifically about those --

3 well, do you know how many --

4 (Brief interruption.)

5 THE VIDEOGRAPHER: I'm sorry,

6 they're controlling it.

7 BY MS. BROWNE:

8 Q. Do you know how many investigative

9 files for Cuyahoga and Summit -- strike that.

10 Do you know how many

11 investigations --

12 MS. BROWNE: Can we go off the

13 record for one second, please?

14 (Thereupon, an off-the-record

15 discussion was had.)

16 MS. BROWNE: We can go back on.

17 Thank you.

18 BY MS. BROWNE:

19 Q. Do you know how many

20 investigations the Board of Pharmacy conducted

21 in Cuyahoga and Summit Counties in the period

22 2014 to the present?

23 A. I do.

24 Q. How many?

25 A. Cuyahoga County, approximately

1 over 700 complaints were investigated in a
2 five-year period.

3 Q. And for Summit County?

4 A. Just over 200. I believe it was
5 231 cases.

6 Q. Other than meeting with the
7 lawyers, reviewing documents, taking a look at
8 the case statistics, suspicious order
9 statistics and some prior conviction
10 investigation files, what, if anything else,
11 did you do to prepare for the deposition?

12 A. That was it. Reviewed my past
13 work history, the laws, the rules, especially
14 as they changed over time.

15 (Thereupon, Defendants' Exhibit
16 Number 1, Notice of Videotape 30(b)(6)
17 Deposition of the State of Ohio Board of
18 Pharmacy, was marked for purposes of
19 identification.)

20 BY MS. BROWNE:

21 Q. I'm going to show you what has
22 been marked as Exhibit 1. Exhibit 1 is the
23 Notice of Videotape 30(b)(6) Deposition of the
24 State of Ohio Board of Pharmacy.

25 Have you seen that document

1 before?

2 A. If this is the one that was sent
3 to us, yes.

4 Q. Do you have an understanding of
5 the topics for which you have been designated
6 as the representative for the Board of Pharmacy
7 today?

8 A. I do.

9 Q. Do you have them memorized, the
10 numbers? You don't have the numbers of the
11 topics memorized, do you?

12 A. I do not.

13 Q. Okay. So if you follow along with
14 me, do you agree you're here for 1 -- the
15 topics themselves start on page 5.

16 A. Yep, yes, ma'am.

17 Q. Topics 1, 2, 4 through 15?

18 A. Hold on.

19 Q. Yep.

20 A. I am aware.

21 Q. Also topic 21?

22 A. Yes, ma'am.

23 Q. Topic 23?

24 A. Yes, ma'am.

25 Q. Topic 24?

1 A. Yes, ma'am.

2 Q. 27?

3 A. Yes, ma'am.

4 Q. 28?

5 A. Yes, ma'am.

6 Q. And 31?

7 A. Yes, ma'am.

8 Q. You are also here in, I think, a
9 more limited capacity for topics 19 and 20 and
10 22; is that right?

11 A. Okay.

12 MR. WAKLEY: I did not designate
13 him for 19, 20 and 22. Here's my letter.

14 MS. BROWNE: I was just looking
15 for that. Thanks.

16 So if you look --

17 MR. WAKLEY: I know, I
18 specifically --

19 MS. BROWNE: He would be prepared
20 to discuss discipline that the board has
21 imposed or other public actions of the board
22 based on actions the board previously provided,
23 so that's why I said subject to certain
24 limitations.

25 MR. WAKLEY: Okay.

1 MS. BROWNE: So that's on number
2 20. I'm sorry, that's on 19 and 20.

3 And then the only other one is 27,
4 which is not mentioned at all in this letter,
5 and 27 is just the board's involvement with the
6 Governor's Cabinet Opiate Action Team.

7 Is there an objection as --

8 MR. WAKLEY: No, he can speak
9 about --

10 MS. BROWNE: Okay.

11 MR. WAKLEY: -- involvement in
12 GCOAT.

13 MS. BROWNE: So we're good, right?

14 MR. WAKLEY: Uh-huh.

15 MS. BROWNE: Thank you.

16 MR. WAKLEY: Subject to the
17 limitations set forth in my letter.

18 MS. BROWNE: Fair enough.

19 BY MS. BROWNE:

20 Q. So with that understanding, you
21 agree with the topics we just talked about and
22 your ability to testify to them today?

23 A. Yes, ma'am.

24 Q. You can set that aside.

25 (Thereupon, Defendants' Exhibit

1 Number 2, Subpoena to testify at a Deposition
2 in a Civil Action, was marked for purposes of
3 identification.)

4 BY MS. BROWNE:

5 Q. Exhibit 2 is a copy of the
6 subpoena to you for testimony in your
7 individual capacity today. Do you see that?

8 A. Yes, ma'am.

9 Q. And if you turn to --

10 A. Should I have two?

11 Q. Not unless you want two.

12 A. Okay.

13 Q. If you turn to the second page,
14 there is a proof of service that notes that you
15 were served on January 11th, 2019. Do you see
16 that?

17 A. I do.

18 Q. And do you understand that in
19 addition to your testimony on behalf of the
20 board, you're here in your individual capacity?

21 A. I am.

22 Q. You can set that aside.

23 What is your current title at --

24 A. Director of compliance and
25 enforcement.

1 Q. Okay. And that's with the Ohio --

2 A. With the Ohio State Board of
3 Pharmacy.

4 Q. And what are your duties as the
5 director of compliance and enforcement?

6 A. I oversee daily operations for our
7 field staff, which includes the hiring of
8 individuals, it includes conducting meetings,
9 setting priorities, managing issues as they
10 arise throughout investigations. We also work
11 in -- within the Pharmacy Practice Act of
12 helping develop rules and changes to rules. As
13 technology and as industry advances, we have a
14 role in that. We also have a proactive
15 inspection program where we inspect licensees.
16 We conduct both administrative and criminal
17 investigations. In addition, we do a lot of
18 educational outreach.

19 Q. Anything else?

20 A. Oversee all complaints coming into
21 the board from the general public, from law
22 enforcement, from other agencies. We hold
23 meetings with stakeholders and other partners,
24 regulatory and law enforcement partners.

25 Q. Anything else?

1 A. Not that I can recall at this
2 time.

3 Q. Is the department of compliance --
4 or the compliance enforcement division
5 responsible for continuing pharmaceutical
6 education?

7 A. It is not responsible for that.
8 That is a licensing function that ensures
9 continuing education for the pharmacist;
10 however, if there's a violation it would be
11 referred to us to investigate. Of a licensee,
12 obviously.

13 Q. Do you share these
14 responsibilities with anybody else?

15 A. I do. I have a chief of
16 investigations.

17 Q. Who is that?

18 A. Tom Pyles. I also have a chief
19 pharmacist, Jenni Wai. We also have an
20 administrative supervisor, Yolanda Freeman,
21 five regional supervisors and two agent
22 supervisors.

23 Would you like the names of the
24 regional supervisors?

25 Q. Yes, please.

1 A. Lisa Dietche.

2 Q. What region is she in?

3 A. She is Northeast Ohio. Kevin
4 Flaharty is Southeast Ohio, Michael Poe is
5 Southwest region, Mark Keeley is Northwest
6 region, and Jesse Wimberly is medical
7 marijuana.

8 And then the two agent
9 supervisors, there's one assigned to Northeast
10 Ohio, which would be John West -- I'm sorry,
11 John Bonish is in Northeast Ohio, John West is
12 in Southeast Ohio.

13 Q. Do you have regular meetings with
14 -- let me ask you this: The individuals we
15 just talked about from Mr. Pyles through
16 Mr. West, those individuals all report to you?

17 A. The chain of command is that Chief
18 Pyles -- the regional supervisors report to
19 Chief Pyles, the people that report to me are
20 Chief Pyles, Chief Jenni Wai, and Yolanda
21 Freeman.

22 Q. What is the role of the regional
23 supervisors?

24 A. They are to manage everything in
25 that region with their team. Each region, we

1 restructured the region -- or the field staff
2 workforce a couple years ago, and each regional
3 supervisor is responsible for managing their
4 field staff in each region; and depending on
5 the number of licensees and the number of
6 cases, depends on the amount of field staff
7 allocated to the various regions.

8 Q. Is Summit County Northeast Ohio?

9 A. It is, yes, ma'am.

10 Q. And is Cuyahoga Northwest?

11 A. Cuyahoga is Northeast.

12 Q. It's also Northeast, okay.

13 Do you know how many individuals
14 are on the field staff in Northeast Ohio?

15 A. If you give me one second, I can
16 tell you.

17 Q. Okay.

18 A. Ten field staff, approximately.

19 Q. Were you writing down the names to
20 try to remember?

21 A. I was, yes.

22 Q. Okay. To whom do you report?

23 A. The executive director, Steve
24 Schierholt.

25 Q. Do you have regular meetings with

1 your chiefs and Ms. Freeman?

2 A. I have regular meetings with the
3 chiefs and the regional supervisors on a weekly
4 basis.

5 Q. Are minutes kept of those
6 meetings?

7 A. Not so-called minutes, but an
8 agenda. We have a very specific agenda.

9 Q. And does anyone maintain those
10 agendas?

11 A. Yes.

12 Q. Who is that?

13 A. Yolanda Freeman.

14 Q. Are notes or follow-up action
15 items generated from those meetings?

16 A. Yes, ma'am.

17 Q. And are those circulated?

18 A. Yes, ma'am.

19 Q. To whom?

20 A. To the regional -- the agenda,
21 which those notes would be kept, are -- the
22 action items are on the agendas.

23 Q. And are they circulated
24 electronically to the meeting participants?

25 A. Yes, ma'am.

1 Q. How often do you meet with
2 Mr. Schierholt?

3 A. Scheduled, probably weekly, but
4 probably more often than that.

5 Q. And are agendas generated for the
6 weekly meetings with Mr. Schierholt?

7 A. No, ma'am.

8 Q. Are notes or action items
9 generated as a result of the meetings with
10 Mr. Schierholt?

11 A. Yes, but nothing formal.

12 Q. Do you meet with him -- and the
13 weekly meetings, are those one-on-one or are
14 those with other of his reports?

15 A. Both.

16 Q. Okay. When others are part of the
17 meetings, who are the others?

18 A. It would be all the department
19 heads. And there is an agenda for that
20 meeting, I apologize. So it would be all the
21 department heads.

22 Q. How many department heads are
23 there?

24 A. You have licensing, compliance and
25 enforcement, administration, legal, and OARRS

1 or informational systems.

2 Q. An agenda is circulated for the
3 meetings that involve licensing, compliance,
4 admin, legal and OARRS?

5 A. Yes, ma'am.

6 Q. Are minutes or action items
7 generated through those meetings?

8 A. On the agenda there is, yes.

9 Q. And are those circulated after the
10 meeting?

11 A. Yes, normally.

12 Q. Who circulates them?

13 A. Steve Schierholt's assistant,
14 Brenda Cooper.

15 Q. Are those agendas with action
16 items circulated only to the meeting
17 participants?

18 A. Yes, ma'am.

19 Q. Is there a system in place to
20 track the completion of the action items?

21 A. Only when we have discussions
22 about them, they're removed from the list.

23 Q. Other than your weekly meeting
24 with your chiefs and the regional supervisors,
25 do you have any other regularly scheduled

1 meetings with the individuals in the compliance
2 and enforcement department?

3 A. Yes, we have a quarterly meeting
4 and an annual meeting.

5 Q. What is the purpose of the
6 quarterly meeting?

7 A. To establish our priorities for
8 the next quarter, address issues that we may be
9 having, whether it's from personnel to case
10 types. They're normally a day long. And then
11 we set priorities or goals for the next
12 quarter.

13 Q. Is there any writing coming out of
14 the quarterly meeting, an agenda, action items,
15 what have you?

16 A. Yes, ma'am.

17 Q. And how would you describe the
18 written product?

19 A. Again, action items are on the
20 agenda that's carried over from the weekly
21 meetings to the quarterly meetings. At the end
22 of the quarterly meeting, additionally, we have
23 our goals and objectives that we call Rocks to
24 get done.

25 Q. And is there a system in place to

1 monitor whether the goals and objectives have
2 been met?

3 A. At each quarter we review them for
4 completion and there's ongoing conversation at
5 the weekly meetings in reference to the Rocks
6 being completed. It's a business management
7 system.

8 Q. And the annual meetings, what is
9 the purpose of the annual meetings?

10 A. Again, to review -- to review the
11 prior quarter's goals, to set new goals, to
12 discuss issues, challenges, anything -- any
13 topics that may have came up during that
14 quarter or any problems, discuss personnel,
15 staffing, regular business functions.

16 Q. You mentioned that the quarterly
17 meeting is approximately a day long. How long
18 is the annual meeting?

19 A. Two days.

20 Q. Is that on-site?

21 A. Most of the time, no, it's at a
22 state park, like a lodge for the state parks.

23 Q. Are there Rocks generated through
24 this annual meeting?

25 A. Yes, ma'am. It takes the place of

1 the fourth quarter meeting.

2 Q. I see. How long have you been a
3 director of compliance and enforcement?

4 A. Since 2016.

5 Q. Were you with the -- so let me
6 just -- I should have said this earlier. If I
7 refer to the Board of Pharmacy as the board or
8 the BOP, will you understand that I'm referring
9 to the Ohio State Board of Pharmacy?

10 A. Yes, ma'am.

11 Q. Thank you.

12 Did you have any roles with the
13 board prior to 2016?

14 A. Yes, I've had various roles since
15 2008. I started out as a compliance agent.

16 Q. What was your role as a compliance
17 agent?

18 A. I inspected facilities that
19 stored, distributed, sold, manufactured
20 dangerous drugs, investigated drug law
21 violations of Ohio Revised Code, Ohio
22 Administrative Code and the federal CFR.

23 Q. Did you have any particular
24 training to become a compliance agent?

25 A. Prior to joining the board I was

1 with Delaware County sheriff's office, so I
2 have -- I'm OPOTA certified, Ohio Peace Officer
3 certified, and almost 15 -- well, over 15 years
4 prior law enforcement experience in
5 investigations prior to coming to the board.

6 Q. How long were you with the
7 Delaware County sheriff's office?

8 A. From 2000 -- or, I'm sorry, from
9 1995 to 2008.

10 Q. And why did you take the position
11 with the board?

12 A. Change of pace, less hours, it was
13 an intriguing opportunity.

14 Q. How long were you a compliance
15 agent?

16 A. Until 2010.

17 Q. What was your next position?

18 A. I was a compliance supervisor.

19 Q. How did your role change from
20 being a compliance agent to a compliance
21 supervisor?

22 A. As a compliance supervisor, at the
23 time the structure -- there was two regional
24 supervisors and then the field staff, and it
25 was a daily operations position, again managing

1 it. However, we had a smaller staff size at
2 that point in time, so it was more manageable.
3 And I reported to the assistant executive
4 director who was in charge of compliance and
5 enforcement.

6 Q. Who was the assistant executive
7 director in charge of compliance and
8 enforcement at the time that you were the -- a
9 compliance supervisor?

10 A. John Whittington.

11 Q. What was your next position with
12 the board?

13 A. 2014 I was the interim assistant
14 executive director for a time period due to an
15 illness, a lengthy time off of our current
16 assistant executive director at that time.

17 Q. So you were a compliance
18 supervisor from 2010 to 2014?

19 A. Yes, ma'am.

20 Q. And then in 2014 you became the
21 interim assistant executive director?

22 A. Yes, ma'am.

23 Q. Of compliance or of the entire
24 board?

25 A. At the time our -- the title was

1 assistant executive director; however, the
2 responsibilities of the assistant executive
3 director was over compliance and enforcement.

4 Q. Was there -- if you were the
5 assistant executive director, was there an
6 executive director in place?

7 A. Yes, ma'am.

8 Q. Who was that?

9 A. Kyle Parker.

10 Q. How long were you the interim
11 assistant executive director?

12 A. Less than a year, and then I was
13 appointed to interim executive director for
14 approximately two months.

15 Q. And then from there you became the
16 director of compliance and enforcement?

17 A. No, ma'am.

18 Q. Okay. What was next?

19 A. I went back to compliance and
20 enforcement supervisor until 2000 -- yeah,
21 until 2016. And also in 2016 I did a short
22 stint as the interim executive director of the
23 Ohio Embalmers and Funeral Board of Directors.

24 Q. What prepared you for that
25 position?

1 A. I would say my work experiences
2 with the Board of Pharmacy had been and I had
3 been in various leadership roles prior to
4 coming to the board.

5 Q. And for what period of time were
6 you the interim director of the Embalmers and
7 Funeral --

8 A. Very short period, less than two
9 months.

10 Q. Okay. Backing up, you were a
11 Delaware County -- you were in the Delaware
12 County sheriff's office from '95 to 2008,
13 correct?

14 A. Yes, ma'am.

15 Q. What did you do prior to that?

16 A. I worked at New Albany police
17 department as a police officer.

18 Q. For what period of time?

19 A. '94 to '95.

20 Q. What did you do prior to 1994?

21 A. I worked for my family's stucco
22 company as a manual laborer and had some
23 odd-and-end jobs through high school.

24 Q. Do you have any formal education
25 since high school?

1 A. Yes, ma'am, I've had various
2 trainings. Obviously I'm OPOTA certified, I've
3 had some college classes. I've also taken
4 numerous trainings, educational leadership
5 types of trainings throughout the years.

6 Q. And you said OPOTA certified?

7 A. Yes, ma'am.

8 Q. That's the Peace Officer?

9 A. Ohio Peace Officer.

10 Q. What is the exact -- what are the
11 letters, is it O-P-A-T-A or O-P --

12 A. O-P -- O-P-O-T-A, OPOTA.

13 Q. All right. Have you heard the
14 term opioid crisis?

15 A. Yes, ma'am.

16 Q. Have you ever used that term?

17 A. I'm sure I have.

18 Q. What is your understanding of the
19 opioid crisis as it relates to the State of
20 Ohio?

21 A. As it relates to the State of
22 Ohio?

23 Q. Yes.

24 A. Obviously we have an issue with
25 diverted pharmaceuticals, in addition to

1 illicit drugs that are all opiate derivatives,
2 and in 2008 our overdose deaths exceeded those
3 of deaths in motor vehicle accidents. So
4 obviously it is a big issue for the State of
5 Ohio.

6 Q. Is your understanding of the
7 opiate crisis as it relates to the State of
8 Ohio different from how it may relate to Summit
9 or Cuyahoga Counties?

10 A. No, ma'am.

11 Q. Do you have an understanding that
12 there is an opioid crisis in Cuyahoga County?

13 A. I am sure they are in the same
14 boat with the rest of Ohio. I don't know any
15 of their statistics or anything like that, but
16 globally for the State of Ohio there's an
17 issue.

18 Q. Do you have an understanding as to
19 whether there is an opioid crisis specific to
20 Summit County?

21 A. I would believe so.

22 Q. And why do you say that?

23 A. From case investigations, from
24 information from the Ohio Department of Health
25 on overdose deaths, attending drug task force

1 commanders association meetings and hearing the
2 different challenges that the task forces have.

3 Q. Do you have an understanding that
4 the opioid crisis may be worse in Summit County
5 than in Cuyahoga County?

6 A. I do not have that understanding.

7 Q. You do not know one way or the
8 other?

9 A. I don't know, yeah.

10 Q. At what point in time did the
11 board come to realize that there was an opioid
12 crisis?

13 A. I think that before I got to the
14 board we were investigating individuals that
15 were diverting pharmaceutical drugs prior to me
16 getting there.

17 Q. And you joined in 2008?

18 A. Yes, ma'am.

19 Q. So it's your understanding that
20 prior to 2008 the board was aware of an opioid
21 crisis?

22 A. I can tell you that we had had a
23 focus on investigating those who were diverting
24 and we were seeing various drug trends that
25 would make you believe that.

1 Q. When you say you were seeing
2 various drug trends that would make you believe
3 that, what do you mean?

4 A. Sure. So an example of it would
5 be at the time we were seeing a massive amount
6 of Florida prescriptions coming to the State of
7 Ohio from what was labeled as pill mills down
8 in the Florida, Broward County area, and
9 massive amounts of prescriptions.

10 Q. Do you know the types of
11 prescriptions that were coming in from Florida?

12 A. Most of the time they were for
13 hydrocodone, oxycodone, Soma, alprazolam.

14 Q. And do you have an understanding
15 that hydrocodone, oxycodone are opioids?

16 A. Yes, ma'am.

17 Q. And alprazolam is a benzodiazapine?

18 A. Yes, ma'am.

19 Q. What is Soma?

20 A. A muscle relaxer or a mild -- it
21 can also be used as a mild pain reliever.

22 Q. Have you ever used the term
23 diversion in your work at the board?

24 A. Yes, ma'am.

25 Q. What is your understanding of the

1 term diversion?

2 A. My understanding of diversion is
3 when a pharmaceutical prescription is in any
4 way redirected from its legitimate medical use
5 to an illicit use, whether that's to an
6 individual or being sold or being stolen, when
7 it's essentially taken out of the legitimate --
8 the legitimate medical use system to be used
9 illicitly.

10 Q. So do you agree that the transfer
11 from a DEA registered and Ohio licensed entity
12 to another DEA registered and Ohio licensed
13 entity is not diversion?

14 A. Correct, it would be a normal
15 course of business.

16 Q. And do you agree that transfer
17 from a DEA registered and Ohio licensed
18 dispenser to an outpatient who presents a legal
19 prescription written by a licensed prescriber
20 is not diversion?

21 A. As long as it's a legal
22 prescription, yes, ma'am.

23 MS. BROWNE: Can I get AA, please?

24 (Thereupon, Defendants' Exhibit
25 Number 3, Letter Dated September 27, 2006 from

1 the U.S. Department of Justice Drug Enforcement
2 Administration, was marked for purposes of
3 identification.)

4 BY MS. BROWNE:

5 Q. I'm going to hand you what we've
6 marked as Exhibit 3. This is a September 27th,
7 2006 letter from the Drug Enforcement
8 Administration. It bears production BOP_ MDL
9 2nd Production 012217 through 012220.

10 MR. MORIARTY: I'm sorry, Mo, what
11 exhibit number did you assign that?

12 MS. BROWNE: Number 3, Exhibit 3.

13 MR. MORIARTY: Okay. Thank you.

14 BY MS. BROWNE:

15 Q. Have you seen this document
16 before, Mr. Griffin?

17 A. Can you give me a minute to review
18 it?

19 Q. You bet you.

20 (Pause in proceedings.)

21 THE WITNESS: I don't know if I've
22 seen this particular document; however,
23 probably versions of it, or at least I'm
24 familiar with most of the language in here. I
25 can't recall this specific document, though.

1 BY MS. BROWNE:

2 Q. Okay. This was produced by the
3 BOP. Are documents of this type -- let me ask
4 this: You said that you may have seen versions
5 of a letter like this, if not this version.
6 Does the DEA provide the BOP with copies of
7 these types of letters?

8 A. In some incidences I believe they
9 do; however, this one is dated 2006.

10 Q. So before your time?

11 A. Before I was here.

12 Q. Okay. Take a look for me at the
13 second paragraph. The first sentence reads, as
14 each of you is undoubtedly aware, the abuse,
15 open parens, non-medical use, closed parens, of
16 controlled prescription drugs is a serious and
17 growing health problem in this country.

18 Did I read that correctly?

19 A. Yes, ma'am.

20 Q. And there's a footnote to a
21 National Institute on Drug Abuse Research
22 Report from 2005. Do you see that?

23 A. Yes, ma'am.

24 Q. Are you familiar with that report?

25 A. I am not.

1 Q. Okay. On page 2 of Exhibit 3, the
2 second paragraph reads, DEA recognizes that the
3 overwhelming majority of registered
4 distributors act lawfully and take appropriate
5 measures to prevent diversion.

6 Did I read that correctly?

7 A. Yes, ma'am.

8 Q. Has that been your experience in
9 your time at the board, that the overwhelming
10 majority of registered distributors act
11 lawfully?

12 A. Yes, ma'am.

13 Q. On the third page of this document
14 under the heading circumstances that might be
15 indicative of diversion, under number 1 is
16 ordering excessive quantities of a limited
17 variety of controlled substances, open parens,
18 e.g. ordering only phentermine, hydrocodone and
19 alprazolam, closed parens, while ordering few,
20 if any, other drugs.

21 Did I read that correctly?

22 A. Yes, ma'am.

23 Q. When we were talking about the
24 drugs coming from Florida, you mentioned
25 hydrocodone and alprazolam, correct?

1 A. Yes, ma'am.

2 Q. And those are drugs that, from
3 your understanding, were coming from pill
4 mills, among other places, into the State of
5 Ohio?

6 A. Not the pills, the prescriptions,
7 the actual paper prescriptions.

8 Q. Okay. So you can set that aside.

9 When you testified about what was
10 coming up from Ohio (sic), it wasn't the drugs,
11 it was the paper prescriptions that were coming
12 up to Ohio from Florida?

13 A. Yeah, coming from Florida to Ohio.
14 At the time when I joined the board, it seemed
15 like this was a growing trend and it wasn't the
16 -- I'm sure the pills were, however, but what
17 we were seeing is a lot of paper prescriptions
18 coming in from Florida.

19 Q. Okay. So other than paper
20 prescriptions coming in from Florida, what, if
21 any, other ways do you understand that
22 prescription opioids have been diverted?

23 A. Okay. There's numerous ways.
24 Let's start with your very basic drug theft.
25 That could be a theft at a wholesale

1 distributor, that could be a theft at a
2 pharmacy, a retail pharmacy, there could be a
3 theft in a hospital. It could also include
4 doctors' offices, clinics, veterinarian
5 facilities, dentists' offices. Really anywhere
6 controlled substances are stored you run the
7 risk of theft diversion of controlled
8 substances and/or dangerous drugs.

9 The second means of diversion
10 would be illegal processing of drug documents,
11 producing false prescriptions, changing
12 quantity amounts on a legitimate prescription
13 that was written for legitimate means, but
14 changing the quantity numbers on those types of
15 prescriptions, forging any type of document,
16 whether it's an order form, any type of drug
17 document to secure a controlled substance.

18 Number three, obviously, you have
19 doctor shoppers, those that are deceiving
20 physicians and going to multiple physicians to
21 get a similar or like medication where you have
22 overlapping drug therapy, and then filling them
23 at, most of the time, different pharmacies. So
24 you have doctor shoppers that also create
25 diversion.

1 Additionally to that you have drug
2 trafficking. You have physicians that are
3 operating essentially pill mills, if you will,
4 where they're taking cash payments for
5 prescriptions that would not be for legitimate
6 medical use.

7 And we sort of saw -- we saw all
8 of those types of diversions when I came to the
9 board in 2008.

10 Q. When you came to the board in
11 2008, had these types of diversion been
12 ongoing?

13 A. I'm sure they had been. The board
14 had conducted, from what I heard, what I had
15 learned when I got here, numerous
16 investigations years prior to me being there;
17 and being assigned as a drug task force
18 commander, I was well aware of the different
19 types of diversions that were out there.

20 Q. When you were with the Delaware
21 County sheriff's office, did you -- were you
22 working at all in drug-related offenses?

23 A. Yes, ma'am.

24 Q. What, if any -- did you ever --
25 did you ever participate in investigations or,

1 I guess -- well, let's say investigations
2 directed toward criminal activity that related
3 to opioids?

4 A. Yes, ma'am.

5 Q. How frequently did that occur?

6 A. I was a drug task force commander,
7 we did that on a daily basis. We had long-term
8 investigations and street-level investigations
9 that range from hand-to-hand buys to long-term
10 drug investigations.

11 Q. Did there come a time while you
12 were with the Delaware County sheriff's office
13 that you noticed an uptake -- an uptick in
14 opioid-related crimes?

15 A. It wasn't until I got to the drug
16 task force that I realized that the
17 relationship between violent crimes and
18 property crimes were so closely related to
19 illegal drug activity. During my time as a
20 detective prior to being assigned to the drug
21 task force, every suspect you interviewed most
22 of the time was a drug-related incident. I
23 never -- all of them said the reason that they
24 were stealing was to get money for drugs.

25 Q. And when you -- when did you

1 become the commander of the drug task force?

2 A. '02.

3 Q. And it was after '02 that you
4 started noticing more of these crimes related
5 specifically to opioids?

6 A. No, I would say when I was
7 assigned to the detective bureau in 2000. I
8 started out as a general detective, then I
9 moved into major crimes which covered rape,
10 robbery, homicide.

11 Q. And so it was at that time when
12 you noticed the --

13 A. The correlation between drug
14 crimes, property crimes and violent crimes, or
15 the uptick in drug-related crimes.

16 Q. I'm talking here specifically
17 about opioids versus like meth.

18 A. Okay. I think we always --
19 because you wouldn't -- you would have anybody
20 from selling their own prescription to people
21 stealing drugs. It was -- I can't tell you how
22 many burglaries or reported thefts that we had
23 of prescription medications. It was a lot.

24 MS. BROWNE: We've been going
25 about an hour. Do you want to take a break?

1 MR. WAKLEY: Yeah.

2 THE VIDEOGRAPHER: We're off the
3 record.

4 (Recess taken.)

5 THE VIDEOGRAPHER: We're on the
6 record.

7 BY MS. BROWNE:

8 Q. So, Mr. Griffin, we were talking a
9 little bit about diversion and what you saw
10 when you were the commander of the drug task
11 force in the Delaware County sheriff's
12 department?

13 A. Correct.

14 Q. I know that there is a sheriff's
15 department in Summit and there's a sheriff's
16 department in Cuyahoga. Do you have an
17 understanding about the jurisdictional
18 responsibilities of, for example, Delaware
19 County versus a place like Summit or Cuyahoga?
20 Not a good question, okay.

21 Delaware County is a smaller
22 county than Cuyahoga County, correct?

23 A. Yes, ma'am.

24 Q. Does Delaware County have a police
25 force in addition to the sheriff's office?

1 A. Yes, ma'am, or Delaware City does.

2 Q. What are the roles -- when you
3 were with the Delaware County sheriff's
4 department, how did the role of the sheriff's
5 department differ from the role of the police
6 department?

7 A. The police department is in charge
8 of the incorporated area or provides law
9 enforcement services to an incorporated area.
10 So a city, a small municipality or townships
11 could have their own police departments; a
12 sheriff had -- a sheriff's office has original
13 jurisdiction over the entire county, also
14 provides the jail -- also is in charge of the
15 jail, also provides court security, and also
16 provides administrative services for subpoenas
17 and different legal papers.

18 Q. And do you know if that is the
19 case in all Ohio counties; for example, in
20 Summit County does the Summit County sheriff's
21 department have original jurisdiction the same
22 way that you described Delaware County did, and
23 then the police -- the police departments have
24 separate roles?

25 A. I believe so. I do know that

1 Cuyahoga operates a little differently. I
2 don't know if they have like a patrol division
3 and different things like that. I know
4 Cuyahoga's main function is the jail.

5 Q. When you were with Delaware County
6 did the police department of Delaware City
7 report to the sheriff's department?

8 A. No, ma'am. They are a separate
9 entity, so each agency within their
10 jurisdiction is their own separate entity, they
11 don't report to anybody. However, the drug
12 task force that I was in charge of was a
13 multi-agency jurisdiction, and so agencies
14 would assign people to our task force and we
15 would work cases jointly within everyone's
16 jurisdiction.

17 Q. When you said it was multi-agency,
18 the task force that you were commander of in
19 Delaware County, what agencies are you talking
20 about?

21 A. So obviously Delaware County
22 sheriff's office, Delaware City police
23 department, Genoa Township police department,
24 Sunbury police department, Powell police
25 department, and the Delaware County

1 prosecutor's office.

2 Q. Who --

3 A. Oh, I'm sorry, and Westerville
4 City police department and Worthington City
5 police department.

6 Q. Who started the task force, the
7 drug task force?

8 A. I'm assuming the sheriff's office
9 way before I got there.

10 Q. So the drug task force was in
11 place prior to your joining the Delaware County
12 sheriff's department?

13 A. Yes, ma'am.

14 Q. Did the -- did the type of drug --
15 let me ask you this: Did the focus of the drug
16 task force change at all depending on an influx
17 of a certain drug in the community?

18 A. Sure, yeah, absolutely. We -- you
19 could -- pricing and availability were impacted
20 by what was going on nationally.

21 Q. So when you took over in 2002 as
22 the commander of the drug task force, what was
23 the drug of focus, if you will, in 2002?

24 A. I don't know if there was a
25 specific focus because we -- it was anything,

1 any type of illegal substance that we would
2 investigate. However, predominantly I would
3 say the daily ones were crack cocaine,
4 marijuana, cocaine, and then prescription
5 pills.

6 Q. How long were you the drug force
7 commander?

8 A. Probably until 2000 and -- 2005,
9 2006, and then I was promoted to administrative
10 lieutenant in charge of all of our
11 investigation sections, which also included the
12 drug task force. So they were still -- I still
13 had management responsibilities for the drug
14 task force.

15 Q. So from 2002 through the period
16 when you served as the administrator in charge
17 of all the sections, did you notice one drug
18 sort of waning and another taking more
19 prominence in the crimes that you investigated?

20 A. I think the biggest swing that I
21 would say that you could have -- that we would
22 have seen in there was to heroin.

23 Q. And about what time did you see
24 the swing towards heroin?

25 A. Maybe thereabouts 2000 -- end of

1 2004, 2005 it became much more readily
2 available and extremely cheap.

3 Q. You had mentioned that during the
4 2002 to 2005 time frame that some of the drugs
5 that the task force routinely saw were crack,
6 marijuana, cocaine and prescription pills,
7 correct?

8 A. Uh-huh.

9 Q. At any time did you see an
10 increase in prescription pills being the
11 predominant drug issue in the community?

12 A. I can't say we ever saw a
13 significant increase like we did with heroin.
14 They were always just -- they always seemed to
15 be available.

16 Q. So you mentioned for -- earlier
17 for types of diversion that you've seen, drug
18 theft, and you mentioned from retail
19 pharmacies, hospitals, any place there's a
20 controlled substance stored, illegal processing
21 of --

22 A. Drug documents.

23 Q. -- drug documents, doctor shopping
24 and drug trafficking.

25 Are these types of diversions

1 diversions that the BOP has oversight of?

2 A. We do conduct those types of
3 investigations. As far as complete oversight,
4 no, there are plenty of other agencies that
5 also investigate these types of drug-related
6 crimes.

7 Q. Does the board investigate --
8 well, let me ask you this: If a child steals
9 his parent's hydrocodone prescription from the
10 medicine cabinet, is that diversion?

11 A. Yes.

12 Q. Does the Board of Pharmacy
13 investigate that?

14 A. We would not. We would refer that
15 to local law enforcement.

16 Q. How would the Board of Pharmacy
17 know when a kid is stealing his parent's opioid
18 medication?

19 A. We wouldn't unless the parent or
20 somebody reported it.

21 Q. Have you ever in your experience
22 at the Board of Pharmacy participated in an
23 investigation of an individual who had been
24 stealing medication from a -- from a family
25 member?

1 A. I don't believe so.

2 Q. Do you know of any in the history
3 of the Board of Pharmacy where the Board of
4 Pharmacy has investigated an individual who had
5 been stealing a relative's opioid prescription?

6 A. I'm not sure. I don't know. The
7 only type of scenario I could think of would be
8 a relative from an elderly family member.

9 Q. And you think you may have
10 investigated -- you, being the board, have
11 investigated a situation where a relative stole
12 a medication from an elderly family member?

13 A. I can't recall.

14 Q. So other than those four types of
15 diversion we talked about and potentially when
16 a relative steals an opioid medication from a
17 family member, those are the types of diversion
18 over which the board has some investigative
19 capacity?

20 A. Yes, ma'am, and I would also
21 include in there that those can take different
22 forms. Prescription -- illegal processing of
23 drug documents can come anywhere from an
24 individual printing their own prescriptions,
25 to, again, changing quantity amounts, to -- the

1 diversion schemes can come in various different
2 forms, in different ways.

3 Q. Have you heard of McKesson
4 Corporation?

5 A. I have.

6 Q. What is McKesson?

7 A. They're a drug wholesaler.

8 Q. What about Cardinal Health, have
9 you heard of Cardinal Health?

10 A. Yes, ma'am.

11 Q. Do you know what they do?

12 A. They are also a wholesaler.

13 Q. What about AmerisourceBergen, have
14 you heard of them?

15 A. Yes, ma'am.

16 Q. And do you know what they do?

17 A. They are also a wholesaler.

18 Q. Do you know approximately how many
19 wholesale pharmaceutical distributors do
20 business in Ohio?

21 A. I do not, no, off the top of my
22 head.

23 Q. Would you be surprised to learn
24 it's more than 500?

25 A. I would be surprised if it was

1 over 500, but I'm sure there's plenty of
2 out-of-state distributors that ship to the
3 State of Ohio.

4 Q. Distributors who do business --

5 A. Actually, can I correct that
6 answer?

7 Q. Yes, you may.

8 A. No, I would not be surprised if
9 it's over 500.

10 Q. And why is that?

11 A. Because there's plenty of places
12 that are shipping controlled substances and
13 dangerous drugs into the State of Ohio that we
14 license outside of the State of Ohio.

15 Q. Wholesale pharmaceutical
16 distributors who do business in Ohio have to be
17 licensed to operate in Ohio, correct?

18 A. Correct.

19 Q. And the BOP is the agency
20 responsible for licensing wholesale drug
21 distributors in Ohio?

22 A. Yes, ma'am.

23 Q. Information about whether an
24 entity is licensed -- a wholesale entity is
25 licensed in the State of Ohio is publicly

1 available?

2 A. Yes, ma'am.

3 Q. And can one access that through
4 the BOP website?

5 A. Yes, ma'am.

6 Q. The public information identifies
7 when a license was issued to a wholesaler,
8 correct?

9 A. I believe so.

10 Q. Does it --

11 A. We recently changed licensing
12 systems.

13 Q. Does it identify the expiration
14 date of a wholesale license?

15 A. I believe so.

16 Q. Does the public information about
17 a wholesaler indicate whether the wholesaler
18 has ever had any discipline?

19 A. It does.

20 Q. Has that type of information, the
21 licensee period and whether action has been
22 ever taken against a licensee, always been
23 publicly available?

24 A. To my knowledge it's been -- since
25 2008 when I started, it was publicly available.

1 Q. And you don't know whether prior
2 to 2008 that information was publicly
3 available?

4 A. I would assume that it was, but I
5 do not know.

6 Q. If an individual today wanted to
7 see who was licensed in 2004, would that
8 individual be able to access that information
9 on the BOP website?

10 A. I would think that it would -- you
11 could and it would show an inactive status.

12 Q. Wholesale distributors in the
13 State of Ohio also have to be registered with
14 the DEA; is that right?

15 A. If they're selling controlled
16 substances.

17 Q. Are you aware of any wholesale
18 distributor -- well, strike that.

19 What, if any, understanding do you
20 have of the role of a dispenser in preventing
21 diversion?

22 A. Of a dispenser?

23 Q. Yes, sir.

24 A. So if we're using it as the term
25 of a pharmacy, that the prescription or order

1 is for a legitimate medical purpose prior to
2 dispensing.

3 Q. Physicians can be dispensers also,
4 right?

5 A. They can. They can provide up to
6 a 72-hour supply of a controlled substance.

7 Q. What, if any, role does a
8 wholesale manufacturer have in preventing
9 diversion?

10 A. They should know their clients,
11 they should know the rules and the laws around
12 what an individual prescriber can personally
13 furnish. They should also be mindful of any
14 type of suspicious orders. They should take
15 steps to ensure security and control of drug
16 stock, whether it's at their facility or
17 whether it is in transit to a retail
18 distributor or a prescriber or a DEA
19 registrant.

20 Q. Does a wholesale distributor have
21 any role in preventing diversion?

22 A. Absolutely.

23 Q. What is that?

24 A. Again, security and control of the
25 drug stock as it is -- whether it's stored at

1 their facility, whether it's in transit at
2 their facility, and to ensure that -- that they
3 are selling to a licensed entity that is doing
4 business appropriately.

5 Q. Do individual pharmacists have a
6 role in preventing diversion?

7 A. Absolutely.

8 Q. What is that?

9 A. To ensure that the prescription or
10 the dispensing -- or order is for a legitimate
11 medical purpose prior to dispensing of a
12 controlled substance and/or dangerous drug.

13 Q. The board requires -- we talked a
14 little bit about this. The board requires CPE
15 or continuing pharmaceutical education for
16 registered pharmacists; is that correct?

17 A. Yes, ma'am.

18 Q. Does the board -- what, if any,
19 role does the board have in recommending areas
20 for CPE credit?

21 A. That's actually up to -- sometimes
22 the board will make some CE requirements
23 depending on industry change, depending on
24 maybe issues that are seen, whether it may be
25 patient safety related to errors in dispensing.

1 In addition, we do -- we've done hundreds of
2 presentations on law updates for CE. We also
3 provide a CPE quiz on our website, a yearly
4 one. So I think there's numerous ways the
5 board is involved in monitoring the CPE.

6 Q. The board identifies CPE
7 opportunities in its newsletters, correct?

8 A. Yes, ma'am.

9 Q. Does the board work with preferred
10 CPE providers?

11 A. I don't know if we would call them
12 preferred CPE providers. We don't -- to my
13 knowledge, we don't endorse one CPE provider
14 over another.

15 Q. You said when there are changes to
16 rules, and I'm paraphrasing, then the board can
17 suggest certain areas of continuing education;
18 is that right?

19 A. I don't know if it's dictated
20 around the rules specifically, but we have
21 required different types of CE depending on
22 changes in the industry.

23 Q. For example, for lawyers where
24 there's a continuing education requirement
25 there will be a requirement of, say, four hours

1 of ethics and then your other ten hours can be
2 anything else. So does the pharmacy board have
3 something where you've got to have X hours of a
4 certain kind of continuing education versus any
5 other general type of --

6 A. We do. There's a requirement for
7 jurisprudence hours. I don't know the exact
8 hours, but there is a requirement for law.

9 Q. What is the board's role, if any,
10 in preventing abuse of heroin?

11 A. None. We don't investigate
12 illicit drugs, being Schedule 1's.

13 Q. What about fentanyl?

14 A. There's two different types of
15 fentanyl. There's clandestine illicit fentanyl
16 and there's pharmaceutical grade fentanyl that
17 is in the closed loop of distribution that we
18 would investigate crimes or violations of.

19 Q. So the board has no role in
20 preventing the use or abuse of heroin or
21 illicit fentanyl, correct?

22 A. No, ma'am.

23 Q. You had mentioned that you saw at
24 the Delaware County sheriff's department an
25 uptick in heroin-related crimes around the

1 2004, 2005 period, correct?

2 A. Yes, ma'am.

3 Q. In your role at the Board of
4 Pharmacy, do you keep track of or have any
5 insight into the particular drugs that are at
6 play in the opioid crisis that we talked about
7 earlier?

8 A. Can you re-ask that question?

9 Q. Sure.

10 A. Sorry.

11 Q. No problem.

12 Earlier this morning we talked
13 about that term opioid crisis and you
14 acknowledged that you're aware of an opioid
15 crisis in the State of Ohio generally, correct?

16 A. Yes, ma'am.

17 Q. Do you have any understanding as
18 to the role that heroin and illicit fentanyl
19 play in the opioid crisis as opposed to
20 prescription pharmaceuticals?

21 A. I do.

22 Q. What is that understanding?

23 A. It's very prevalent. From the
24 information that I've received from people that
25 I've talked to, from the drug task force

1 commanders that we've spoken to, to other
2 agencies that we work with on a collective
3 basis, we have that understanding.

4 Q. When you say it's very prevalent,
5 do you mean heroin and other illicit opioids?

6 A. Yes, that was the question.

7 Q. So you do agree the board has a
8 role in preventing prescription drug abuse,
9 correct?

10 A. Yes, ma'am.

11 Q. And the board has a role in
12 preventing prescription drug diversion?

13 A. Yes, ma'am.

14 Q. Does the board have a role in
15 preventing opioid abuse generally?

16 A. When it comes to prescription
17 drugs, yes.

18 Q. How does the board work to fulfill
19 its role in preventing prescription drug abuse?

20 A. I think this falls into four types
21 of areas. I think the first area would be
22 regulatory and administrative. To start with,
23 as an administrative piece we've, you know,
24 expanded our scope and authority by changing
25 rules or requesting rule changes and law

1 changes to help combat what we were seeing.

2 In addition to that regulatory
3 administrative function, we do proactive
4 inspections at licensed locations. Those are
5 also unannounced inspections and also, I
6 believe, education opportunities during the
7 regulatory piece of it.

8 We also do background
9 investigations on licensees that prevent --
10 or ensure that people are properly getting
11 licensed. In addition to that, we have an
12 enforcement component that is our
13 administrative and criminal enforcement part of
14 that, that I believe helps suppress drug abuse;
15 and most of the time our criminal
16 investigations will parallel an administrative
17 investigation. We've investigated and
18 convicted hundreds over the past years for
19 different diversion schemes.

20 In addition, I think education
21 plays a huge role in our prevention efforts.
22 We have a monthly newsletter, we do email
23 blasts, we've redesigned our website twice. In
24 addition, we do RP round tables for responsible
25 persons for licensees. We do CE round tables,

1 events with stakeholders. We do loss
2 prevention round tables. We travel around to
3 the boards of pharmacies to give presentations.

4 We also -- we also reorganized --
5 when we reorganized our field staff, I think
6 we're one of the few agencies that you can call
7 and talk to a pharmacist and ask a question.
8 You get a live pharmacist when you call to ask
9 a question at our agency. So I think education
10 and being available for questions is very
11 important to us.

12 In addition to other efforts we've
13 made, I would say, surround the OARRS program,
14 and I think over the past several years it's
15 made leaps and bounds enhancements.
16 Integration of OARRS into work flow, I think,
17 was a significant change to put the OARRS
18 information at the fingertips of a prescriber
19 or a dispensing pharmacist. Integrating it
20 into the workflow has been huge. Connecting
21 OARRS to PMPs across the country and
22 surrounding states, I think, was a huge effort.
23 That way our prescribers and our pharmacists
24 have that information available to them.

25 In addition, to adding MED scores

1 to the OARRS reports, doing proactive
2 prescriber reports for physicians and clinics,
3 the -- also the most recent additions of the
4 NARx care and providing an overdose risk score
5 analysis on the report. It's all information
6 that is, I feel, key to the healthcare
7 professional.

8 Q. You've given me a whole list of
9 things that the board does in its role in
10 preventing prescription drug abuse. Does that
11 role and the -- the items you just identified
12 for me differ at all with regard to preventing
13 diversion?

14 A. I would say that we take -- I
15 wouldn't say they would differ much; however,
16 with our regulatory inspections we do have an
17 emphasis on security and control. And whether
18 that security and control is at a hospital,
19 whether that security and control is at a
20 veterinarian's office or an EMS unit, we put a
21 very high emphasis on security and control
22 during our inspection process, just with the
23 amount of drug theft that we've experienced or
24 that the board experiences and the types of
25 investigations.

1 Additionally, we put in a rule --
2 we are one of six states that did not license
3 technicians and we started -- excuse me,
4 register technicians. We don't license them,
5 they are registered with us. And prior to the
6 rule going into effect, a pharmacy technician,
7 we could be investigating one for a felony drug
8 crime and they could get a job -- during our
9 investigation they could get fired from one
10 pharmacy and get a job at a pharmacy down the
11 street. So that's allowed us to prevent those
12 types of activities from happening.

13 Q. So you've spoken a bit and
14 mentioned that there are administrative and
15 criminal investigations that the board
16 undertakes; is that right?

17 A. Yes, ma'am.

18 Q. Is there a difference between a
19 criminal investigation as opposed to an
20 administrative investigation in terms of the
21 process?

22 A. Oh, yeah, the process is much
23 different.

24 Q. Okay.

25 A. In an administrative investigation

1 we conduct the investigation, prepare documents
2 and reports, basically are finders-of-fact, and
3 then we submit it to site review process; at
4 which point in time the site review committee
5 will determine if it's appropriate to issue a
6 citation against a licensee.

7 The criminal investigations are
8 mostly different in the fact that the -- the
9 case or the final investigation is submitted to
10 a local prosecutor. Most of the time the
11 county prosecutor of that jurisdiction, or in
12 some cases the U.S. attorney's office, being
13 either in the Northern District or the Southern
14 District of Ohio.

15 On an administrative investigation
16 the end conclusion can be from obviously a
17 finding of not guilty, to a fine, a CE
18 requirement, probation, all the way up to
19 license revocation; and on a criminal
20 investigation, if a person is found guilty,
21 they can serve a prison term.

22 Q. In a criminal investigation the
23 board will still prepare documents and reports
24 through factfinding, correct?

25 A. Yes, ma'am.

1 Q. The difference is that once --
2 between the administrative and the criminal, is
3 that once the board prepares the documents and
4 reports and does its factfinding that, rather
5 than going to the state review, that
6 information is submitted to a local prosecutor;
7 is that right?

8 A. Correct. Can I add something to
9 that?

10 Q. Yeah, you bet.

11 A. In some cases they -- they may go
12 down simultaneous tracks. They may have an
13 administrative investigation and a criminal
14 investigation simultaneously because they're a
15 licensee that we hold. And if it's a licensee
16 of another board, we would notify them of the
17 possible violations, another regulatory board,
18 such as med, nursing, dental, veterinarian.

19 Q. In the course of gathering
20 information for either an administrative or a
21 criminal investigation, does the board collect
22 patient-specific information?

23 A. Yes, ma'am.

24 Q. What type of patient-specific
25 information would the board collect during the

1 process of an investigation?

2 A. Prescription drug records, whether
3 it be dispensings, orders, profiles, and at
4 some point in time on criminal investigations
5 we would get the entire patient file to be
6 reviewed by an expert on some criminal cases.

7 Q. What is a profile? What do you
8 mean by that?

9 A. A patient profile, a list of their
10 -- the drugs that they may be on or be
11 receiving from a specific pharmacy.

12 Q. And how do you obtain a patient
13 profile?

14 A. Depending on where it's from, like
15 a pharmacy has a printout that they give us or
16 that they would give us about the patient's
17 medications.

18 Q. Is that information available on
19 OARRS?

20 A. A patient profile?

21 Q. Yes.

22 A. No, not all of it. Some of it
23 could be because a patient profile is going to
24 list every drug that they're on and OARRS only
25 captures controlled substances and gabapentin.

1 Q. And when you say in a criminal
2 investigation the board could get the entire
3 patient file to be reviewed by an expert,
4 that's a patient's medical file?

5 A. Medical file.

6 Q. And to be reviewed by an expert,
7 is this -- would this be an expert that is on
8 the BOP staff?

9 A. Not an expert on the BOP staff.
10 It would be an outside expert that's hired or
11 contracted.

12 Q. For what purpose?

13 A. To provide an expert opinion on
14 medical scope and practice.

15 Q. Does the board collect information
16 to permit it -- during the course of an
17 investigation, does the board collect
18 information to permit to identify doctor
19 shoppers?

20 A. I don't think I understand your
21 question.

22 Q. Sure. I think you mentioned that
23 - yeah, you did - one of the methods of
24 diversion that the board -- or that the board
25 is aware of is doctor shopping.

1 A. Yes, ma'am.

2 Q. Right?

3 A. Uh-huh.

4 Q. So does the board conduct
5 investigations to identify doctor shoppers?

6 A. Yes, ma'am.

7 Q. And in order to do that, it needs
8 to collect a certain type of information,
9 right?

10 A. Yeah. So most of the time it
11 starts with an OARRS report and then we would
12 collect the original prescriptions or orders,
13 in addition to interviewing the physician or
14 the prescriber.

15 Q. Does the Board of Pharmacy ever on
16 its own -- or has it ever on its own instigated
17 an investigation into a doctor shopper?

18 A. Yes.

19 Q. Under what circumstance?

20 A. We get a monthly report of doctor
21 shoppers that's generated from OARRS.

22 Q. When you say we get this report,
23 who gets it?

24 A. Compliance and enforcement.

25 Q. How long has compliance and

1 enforcement received a monthly report of doctor
2 shoppers from OARRS?

3 A. I can't recall. At least for the
4 last -- I believe for the last three years that
5 it was an automated type of feature, as an
6 automated report.

7 Q. But prior -- so three years ago,
8 2016, prior to 2016 was it possible for OARRS
9 to generate a report of doctor shoppers?

10 A. Yes, ma'am. I'm just not sure how
11 or the frequency of the reports.

12 Q. Prior to 2016 had you seen a
13 doctor shopper report?

14 A. Yes.

15 Q. How frequently; do you recall?

16 A. I don't recall.

17 Q. The board also can identify pill
18 traffickers; is that right? I think drug
19 traffickers. You said one of the means of
20 diversion was drug trafficking by doctors who
21 operate pill mills, take cash for prescriptions
22 that are not for a legitimate medical use.

23 Do you recall telling me that?

24 A. I do.

25 Q. And does the board have the

1 ability to identify drug traffickers?

2 A. I would not say -- OARRS is a tool
3 that we utilize in analyzing the information
4 for prescribers that would appear to be
5 outliers; however, that's not the -- that's
6 just one component of the investigation.

7 Q. If I said OARRS, I meant the board
8 generally. Is the board able to or does it
9 investigate pill traffickers or drug
10 traffickers?

11 A. We investigate prescribers that --
12 that write prescriptions for non-legitimate
13 medical use, and so which is drug trafficking.

14 Q. And how does the board identify
15 prescribers who write for non-legitimate
16 medical use?

17 A. So that's an investigative process
18 and we get the information from various means.
19 I think if I go much further it would be
20 confidential information.

21 Q. Does the board investigate
22 individuals who forge prescriptions?

23 A. We have.

24 Q. And how does the board do that?

25 A. So I think that's sort of a tough

1 question because it's in various ways that we
2 learn about the information, whether it's a
3 complaint, whether it's a phone call from a
4 pharmacy, whatever it may be.

5 In addition, some of them have
6 expanded if you -- it's sort of like pulling
7 the string, when you pull the string and you
8 look at one or two, that you find them. We
9 start to look and we start to find other ones
10 that are on that same pattern or that same
11 geographic area, and so we've identified
12 fraudulent prescriptions in that means also.

13 Q. In the course of conducting an
14 investigation, does the board -- other than
15 looking at patient-specific information, does
16 it look -- we talked a little bit about this,
17 prescriber-specific information. For example,
18 you mentioned that there's an OARRS report, a
19 monthly report of doctor shoppers from OARRS.

20 Is there some type of monthly
21 report about frequent prescribers, if you will?

22 A. Sure. One we have is called a 640
23 list and it's for physicians that are seeing
24 more than 640 patients or issue 640 new
25 prescriptions.

1 Q. And what is the magic of 640?

2 A. It's a calculation that our OARRS
3 director came up with on number of days, number
4 of patients. I'm not sure all the different
5 things he takes into consideration to determine
6 640 patients.

7 Q. Does the prescriber information
8 that the board reviews identify improper
9 combinations of drugs that have been
10 prescribed?

11 A. Improper. I don't know if
12 improper would be the same, but cookie-cutter
13 drug therapy. If every patient gets the same
14 types of drugs, the same quantities, we have
15 identified or OARRS has identified those types
16 of behaviors.

17 Q. The 640 list, that's doctors who
18 have seen more than 640 patients or issued 640
19 new prescriptions in what period of time?

20 A. I believe that's one month.

21 Q. Does the board investigate
22 prescribers who continue to work without a
23 valid license?

24 A. The medical board would do an
25 administrative investigation; however, we have

1 had incidents, and I can't recall specifics,
2 where a prescriber's DEA number -- or, I'm
3 sorry, his medical board license wasn't renewed
4 on time or was suspended and they wrote
5 prescriptions where they shouldn't have. And
6 we also refer those to the local jurisdiction,
7 county prosecutor.

8 Q. But the Board of Pharmacy doesn't
9 get involved in the investigation of physicians
10 or prescribers who are prescribing opioids
11 without a license, be it because the license
12 lapsed or for whatever reason?

13 A. We would.

14 Q. You would?

15 A. Uh-huh.

16 Q. And that is in conjunction with
17 the medical board or is it a separate
18 investigation?

19 A. I think that's hard to say. We
20 would provide them the information. So I would
21 say in conjunction; however, we would submit
22 the case and the facts to the county prosecutor
23 for ultimate decision.

24 Q. Okay. So in a case where a
25 physician is prescribing without a valid

1 license, the administrative punishment, if you
2 will, would come from the medical board and the
3 Board of Pharmacy would refer it for criminal
4 prosecution?

5 A. Yeah, ultimately for the county
6 prosecutor to make the decision whether they
7 want to go forward for an indictment.

8 Q. So the Board of Pharmacy wouldn't
9 be issuing its own administrative sanction, if
10 you will, to a prescriber who has prescribed
11 without a valid license?

12 A. The only sanction we would, would
13 be is if the facility was also licensed, we
14 would take an administrative action on that
15 facility.

16 Q. Got it.

17 Does the board collect
18 dispenser-specific information? So individual
19 pharmacists have to be licensed, correct?

20 A. Correct.

21 Q. Is the board able to identify
22 dispensers who are stealing from their --
23 stealing drugs from their employer?

24 A. Identify people that are stealing
25 drugs, we have no way of identifying that. The

1 normal course is that it is reported, normally
2 via DEA 106 with theft or loss; however, I do
3 know that administrative or regulatory
4 inspections have led to drug theft
5 investigations where recordkeeping was not
6 appropriate or tampered with and uncovered or
7 identified theft.

8 Q. When you say administrative or
9 regulatory inspection, would that have been a
10 board administrative or regulatory inspection
11 that led to the identification of drug theft
12 because of recordkeeping abnormalities?

13 A. Yes, ma'am.

14 Q. And in an occasion where a
15 specific dispenser is stealing drugs from their
16 employer, that's -- that's diversion, right?

17 A. Correct.

18 Q. Is the board able to -- or does it
19 collect -- strike that.

20 Is the board able to identify
21 dispensers who dispense without a valid
22 prescription?

23 A. I'm not sure I understand your
24 question, but I don't -- so a dispenser that is
25 dispensing without a valid prescription.

1 Q. So a pharmacist who is -- so not
2 stealing the drugs for him or herself, a
3 pharmacist who is --

4 A. Not without investigating.

5 Q. -- taking drugs.

6 A. We have no means to look at a
7 dispensing record and say, hey, this one is --

8 Q. So the board can't tell from --
9 does the board have access to dispensing
10 records from pharmacies?

11 A. In OARRS?

12 Q. Yes.

13 A. Yes. All pharmacies report their
14 controlled substances and gabapentin to OARRS,
15 so we can look at that piece of it.

16 Q. But just looking at the dispensing
17 records, the board would be unable to determine
18 whether the prescription -- or whether the
19 medication was dispensed pursuant to a valid
20 prescription?

21 A. We wouldn't know until we
22 investigated.

23 Q. And that's an example of
24 diversion, correct?

25 A. Somebody stealing from a

1 dispenser, yes, or, I'm sorry --

2 Q. A dispenser issuing a medication
3 without a valid prescription.

4 A. Yes, ma'am, it could be.

5 Q. Does the board or is the board
6 able to identify individual dispensers who
7 forge prescriptions?

8 A. No, ma'am.

9 Q. Does the board collect information
10 on the most commonly diverted prescriptions?

11 A. We collect all -- so the drugs
12 that are most commonly diverted, I'm trying to
13 think of a way that we collect that
14 information. We sort of have a good idea
15 through investigations what the most common
16 diverted drugs are. I would say yes, on DEA
17 106s. We collect DEA 106s that shows the
18 amount of theft and loss of various types of
19 drugs.

20 Q. Does the board have access to any
21 manufacturer-specific information; for example,
22 who is making the drugs that are diverted?

23 A. I'm sure we could find out, but we
24 don't collect like data from a manufacturer.

25 Q. For example, could you trace --

1 you've done an investigation, somebody has
2 illegal hydrocodone; is the board able to --
3 meaning it was obtained illegally. Is the
4 board able to trace the manufacturer of a
5 specific medication that's landed in the hands
6 of somebody improperly?

7 A. Sure. If it came from a stock
8 bottle at a pharmacy, you would know the
9 manufacturer by the bottle, the NDC number, lot
10 number, all that other good stuff.

11 Q. Does the board have access to
12 ARCOS data?

13 A. We can request it through DEA.

14 Q. Under what circumstances has the
15 board requested ARCOS data?

16 A. I can't recall any specific off
17 the top of my head. Our staff work with DEA
18 diversion and enforcement agents on a regular
19 basis, they share information, but I can't
20 recall any case-specific times where we've
21 requested it and --

22 Q. Is the board able to identify
23 wholesale distributors that fail to report
24 suspicious orders?

25 A. Not without investigating.

1 Q. Is the board able to identify the
2 wholesale distributors that supply the most
3 prescription opioids in a particular county?

4 A. Can you ask that again?

5 Q. Sure. Is the board able to
6 identify the wholesale -- the particular
7 wholesale distributors that supply the most
8 prescription opioids in a given county?

9 A. I would believe so. I think
10 there's some publicly available data. Well, it
11 wouldn't show by which distributor, but I
12 believe that OARRS could tell you that
13 information.

14 Q. You mentioned that there are
15 individuals at the board who work with DEA
16 agents every day or on a regular basis; is that
17 right?

18 A. Yes, ma'am.

19 Q. And you had mentioned that the
20 board can request ARCOS data. Is OARRS data
21 provided to the DEA?

22 A. They can request OARRS data, yes,
23 for criminal investigations.

24 Q. DEA agents have OARRS accounts,
25 don't they?

1 A. Yes, ma'am.

2 Q. Does anyone at the board have an
3 ARCOS account?

4 A. Not that I know of.

5 MS. BROWNE: All right. Why don't
6 we go off right now. We need to change the
7 DVD.

8 THE VIDEOGRAPHER: We're off the
9 record.

10 (Recess taken.)

11 THE VIDEOGRAPHER: We're on the
12 record.

13 (Thereupon, Defendants' Exhibit
14 Number 4, State of Ohio Board of Pharmacy
15 Complaint Form, was marked for purposes of
16 identification.)

17 BY MS. BROWNE:

18 Q. Mr. Griffin, I've handed you what
19 has been marked Exhibit 4. We printed this
20 from the BOP website. It's the State of Ohio
21 Board of Pharmacy Complaint Form.

22 Have you seen this before?

23 A. Yes, ma'am.

24 Q. What is the purpose of Exhibit 4?

25 A. For anybody to file a complaint in

1 regards to one of our licensees or a complaint
2 with the Board of Pharmacy concerning any type
3 of prescription drug problem; however, we get
4 all kinds of complaints through here.

5 Q. Like what, like other than -- do
6 you mean other than pharmacy-related
7 complaints?

8 A. Sure, yeah. We get them from
9 other states, we get them from anywhere --
10 anything and everything.

11 Q. In your role as the director of
12 compliance and enforcement, do you review
13 complaint forms?

14 A. I do. Me or one of the two chiefs
15 do, two supervisors do.

16 Q. Do you know how many complaints
17 you've received, public complaints you've
18 received during your tenure as the director of
19 compliance and enforcement?

20 A. In total I can't tell you. What I
21 can tell you is in the last five years -- I
22 think we had over 1,000 five years ago and
23 we're probably thereabouts around 2,000,
24 different types of complaints. Maybe just shy
25 of 2,000 as of 2018.

1 Q. Do you just get a notification
2 that a complaint has been filed or does the
3 filled-out complaint actually come to your in
4 box when it's filed?

5 A. It doesn't come to my in box. It
6 comes to a support person, who then collects
7 additional information if it's regards to a
8 licensee that they would put with the
9 complaint, and then we have a process that we
10 call intake review that happens pretty much on
11 a weekly basis where we review any of the
12 complaints that come in.

13 However, we do have a few items
14 that if they were to come in -- this is
15 monitored on an hourly basis, that if a certain
16 type of complaint comes in we would have an
17 immediate response to, such as an act of
18 diversion.

19 Q. Other than an act of diversion,
20 what other types of complaints get an immediate
21 response?

22 A. Risk to public health and/or an
23 impairment issue.

24 Q. What do you mean by an impairment
25 issue?

1 A. A pharmacist that shows up
2 intoxicated or impaired by either drugs or
3 alcohol or appears to be impaired.

4 Q. What is a risk of public health
5 issue?

6 A. It could be a compounding issue.
7 We've been notified by CDC about potential
8 compounding issues where we had to have
9 immediate response to investigate a possible
10 contamination of a compounded drug.

11 Q. And you said the -- in the first
12 instance a complaint goes to a support person?

13 A. Yes, ma'am.

14 Q. Is that an IT person, is it a
15 member of your staff?

16 A. It's a member of our staff,
17 compliance and enforcement.

18 Q. Is it a particular member of the
19 staff?

20 A. We have two people that can
21 receive the complaints and then we have a
22 back-up third.

23 Q. Who are they?

24 A. Susan King and Tracy Simmons would
25 be the two primary, both are administrative

1 professionals; and the third being Yolanda
2 Freeman, who is a supervisor.

3 Q. If the complaint is not one that
4 requires immediate attention, does it ever make
5 its way to you?

6 A. So again, we have an intake review
7 process.

8 Q. Right.

9 A. So all of these complaints are
10 either reviewed by me and one of the chiefs, or
11 the two chiefs, simultaneously. There's always
12 two supervisors on the weekly intake review
13 process that review all the complaints.

14 Q. Is that an assignment, so this
15 week I'm on intake review kind of thing?

16 A. Yeah, it's sort of a rotational
17 basis, but depending on people's schedules we
18 flip all the -- I mean, trade all the time.
19 Chief Pyles is the one that normally schedules
20 all the intake reviews.

21 Q. Is there an intake review meeting
22 once a week?

23 A. Yeah, an intake review, yeah.
24 It's not so much -- yeah, literally we sit
25 down, we review every complaint, any associated

1 information that could be pulled in about if
2 it's a licensee, we review that on a weekly
3 basis; and it is in person at a conference
4 table, so yes, a meeting.

5 Q. Is that procedure written down
6 somewhere?

7 A. I'm sure it is memorialized.

8 Q. What about in the case of either
9 diversion or risk of public health or an
10 impairment issue, you mentioned that those
11 types of complaints get immediate attention,
12 correct?

13 A. Yes.

14 Q. And what does that mean, immediate
15 attention? What is the process?

16 A. So it would be somebody actually
17 going to the facility and starting the
18 investigation. If it's going to be a public
19 health issue, that's going to dictate a
20 pharmacist and probably an agent. If it's a
21 diversion from a retail pharmacy, that's just
22 going to be an agent's response. It sort of
23 depends on the level of what we depend --
24 determine to be expertise in a certain topic or
25 area of pharmacy.

1 Q. So if it's a -- if it's a
2 diversion issue, Susan or Tracy brings the
3 complaint to you or --

4 A. Or to one of the chiefs and it
5 would immediately get assigned.

6 Q. Okay. And when it gets assigned
7 to an agent, that's one that's -- one of the
8 folks who is in the field staff?

9 A. Correct.

10 Q. So you would -- so you or Chief
11 Pyles would contact the supervisor, who would
12 then contact a member of the field staff?

13 A. No, we would send it straight to
14 the agent or the specialist.

15 Q. There's a notation -- or one of
16 the questions on page 2 of the complaint is
17 have you made a complaint to any other
18 government agency, professional association, et
19 cetera, about this matter.

20 Did I read that correctly? It's
21 the final question before that box on the
22 second page.

23 A. Yes.

24 Q. Why is that important?

25 A. Duplicate of services. If it's

1 been notified to the nursing board, we want to
2 make sure that everybody is on the same page.
3 If they're investigating a nurse for diversion,
4 we would coordinate with them as our
5 investigation proceeds, as they're going to
6 have an administrative action along with our
7 criminal action. And that's just an example,
8 but it could be any -- you know, whether it's
9 DEA, nursing board, vet board, dental board,
10 med board. It could be any of them.

11 Or some of them are complaints
12 about insurance, you know, the cost of their
13 co-pay went up, or whatever it may be.

14 Q. Does the board track how many --
15 let me back up.

16 This complaint form is a complaint
17 form for members of the public?

18 A. It can be public or another
19 agency.

20 Q. How frequently do you receive
21 complaints with this format or through this
22 form from other agencies?

23 A. Occasionally they'll submit them.
24 I wouldn't say it's extremely frequently, but
25 occasionally another agency would submit via

1 the online complaint form.

2 Q. In the middle of the -- of page 2,
3 does your complaint involve an OARRS report, do
4 you see that?

5 A. Yep.

6 Q. What does that mean?

7 A. Does it involve an OARRS related
8 complaint, an OARRS report. Doctor writes an
9 OARRS report, doesn't see a script that he
10 wrote or sees -- pulls an OARRS report and
11 there's a script under his name that isn't his.
12 Or a prescriber, I shouldn't just say a doctor.
13 It could be a multitude of issues.

14 Q. But members of the public don't
15 have access to OARRS, do they?

16 A. They do not. An individual can
17 come in and request their OARRS report at our
18 office providing proper identification and we
19 will provide them a copy of their OARRS report.

20 Q. So how many times has the board
21 received a complaint where it involved an OARRS
22 report?

23 A. I couldn't tell you. I have no
24 idea.

25 Q. Do you recall the last time that

1 you investigated -- or that you received a
2 complaint where it involved an OARRS report?

3 A. I can't recall the exact
4 incidence, but it happens.

5 Q. Does the board track whether
6 complaints that it receives have also been made
7 to other agencies?

8 A. We don't track that. That's not
9 -- it's not something that -- it's noted within
10 the complaint, and if the other agency is a
11 partner in the investigation it would be listed
12 in that complaint.

13 Q. Other than through this online
14 portal, if you will, what other ways do board
15 licensees -- or what other ways are
16 investigations of board licensees instigated?

17 A. Sure. So we get complaints via
18 email, we get complaints via phone call, not
19 only to our office in Columbus, but field staff
20 also get emails, phone calls on a regular basis
21 where complaints are generated. The complaints
22 are also generated from in the office because
23 of a DEA 106. There's multiple ways a
24 complaint can be generated. But again, most of
25 the time it's either the online complaint, a

1 phone call or an email.

2 Q. What's the DEA 106?

3 A. It's a commonly referred to form,
4 but it is the reporting of theft and loss.

5 Q. How frequently are DEA 106s
6 reviewed at the board?

7 A. They're reviewed right when they
8 come in; however, every agent or specialist
9 gets a copy of any DEA 106 that is sent to the
10 board for their particular territory or their
11 area of responsibility.

12 Q. So let's say you receive an email.
13 From whom do you receive complaints that
14 generate investigations?

15 A. From who?

16 Q. From whom, yeah. You've told me
17 that you guys get emails, phone calls, you
18 check a DEA 106.

19 A. General public.

20 Q. Okay.

21 A. Other regulatory boards, other law
22 enforcement agencies. Additionally, loss
23 prevention for industry, district managers from
24 industry, pharmacists themselves, interns,
25 pharmacy technicians. It can be any -- it

1 could be anybody that we receive complaints
2 from literally.

3 Q. Okay. Is there one type of entity
4 that makes complaints more frequently than
5 another?

6 A. I would say general public is
7 probably the most predominant, followed up by
8 loss prevention and industry, within the
9 industry.

10 Q. Can you give me an example of a
11 contact -- or complaint from loss prevention
12 within the industry that --

13 A. Sure. They normally give us
14 initial notification if they suspect a theft or
15 loss, and at which point we start an
16 investigation.

17 Q. Is that theft or loss from a
18 pharmacy, from a -- from a warehouse?

19 A. Dentist's office, doctor's office,
20 hospital. Really anywhere. EMS. Anywhere
21 controlled substances or dangerous drugs are
22 stored. But predominantly I would say
23 pharmacies.

24 Q. And how is it that a pharmacy --
25 if you can call to mind a complaint that

1 generated that way, how is it that a pharmacy
2 would have been able to tell that there was a
3 theft or loss?

4 A. Normally they have some type of
5 system in place that monitors their inventory,
6 and when that doesn't match or they have
7 reporting errors that they monitor they notify
8 us.

9 Q. And that's because a pharmacy has
10 records of how much they ordered that came into
11 the pharmacy, correct?

12 A. Uh-huh.

13 Q. And they also have records of how
14 much went out through their prescription
15 records, right?

16 A. Yes, ma'am.

17 Q. And is that type of information
18 also available to the board?

19 A. If we request it, yes.

20 Q. If you request it from whom?

21 A. The pharmacy.

22 Q. The board could routinely compare
23 records of what came into a pharmacy to what
24 goes out?

25 A. We could; however, the question

1 was about a theft or how they determine it. We
2 don't -- I don't think we could tell from our
3 wholesale records and our dispensing records if
4 a theft was occurring.

5 Q. You could tell that there is a --
6 if there's a discrepancy, correct?

7 A. No, because you're missing one
8 piece of the pie, you're missing their on-hand
9 quantity. You're always going to have -- like
10 when we do audits, you have to have the on-hand
11 amount to know if there's a discrepancy. We
12 would know -- we would know how much the
13 on-hand account should be or reported at that
14 point in time; however, they don't line up
15 exactly.

16 Q. When a licensee is being
17 investigated, does that entity receive notice?

18 A. Not necessarily.

19 Q. When the board is conducting an
20 investigation, who does receive notice of an
21 investigation, if anyone?

22 A. Nobody -- not the licensee.

23 Q. If the board is investigating for
24 criminal purposes, does the board notify the
25 prosecutor that the investigation is being

1 undertaken?

2 A. Sometimes, but not always.

3 Q. In what situations would the
4 prosecutor be notified before the investigation
5 is complete?

6 A. I think it would depend on the
7 totality of the investigation. You know, your
8 average drug theft from a retail pharmacy, they
9 wouldn't be notified; however, if it was a
10 longer-term drug trafficking investigation or
11 something that was more complex, we would want
12 to get the prosecutor involved.

13 Q. Compliance and enforcement is
14 responsible for investigations of licensees,
15 right?

16 A. Yes, ma'am.

17 Q. In the case of diversion that
18 involves trafficking --

19 A. Yes, ma'am.

20 Q. -- is that an investigation that
21 also falls within the ambit of compliance and
22 enforcement?

23 A. If a -- so if a prescriber is drug
24 trafficking, does that fall within our purview?

25 Q. Correct.

1 A. Yes, ma'am.

2 Q. You mentioned earlier that you
3 have taken a look at the number of
4 investigative files for Cuyahoga and Summit
5 Counties. Do you recall that?

6 A. Yes, ma'am.

7 Q. You said they were about -- you
8 looked at approximately 700 complaints for
9 Cuyahoga and approximately 231 for Summit
10 County. Do you remember that?

11 A. I did, but that's not what I said.
12 I said that I know the total number of
13 complaints. I did not look at all 700
14 complaints or 231 complaints.

15 Q. Thank you.

16 And that total number of
17 complaints -- so just for the record, you
18 looked at complaints and you were able to tell
19 me, though, that you are aware of approximately
20 700 complaints in Cuyahoga County and
21 approximately 231 complaints in Summit County,
22 correct?

23 A. Yes, ma'am.

24 Q. And that was for the period 2017
25 to the present?

1 A. No, that was a five-year lookback.

2 Q. Do you know how many complaints
3 there have been in 2019?

4 A. I do not.

5 Q. Do you know how many have been in
6 2018?

7 A. I don't know the specific by year
8 for those counties.

9 Q. When a complaint comes in and it's
10 determined that you will undertake an
11 investigation, are there specific documents or
12 rules about documentation that has to be
13 completed in order to -- you know, as part of
14 the investigation?

15 A. So there's reports generated on an
16 investigator's findings.

17 Q. So an investigator doesn't just go
18 out with a notebook and just start writing
19 stuff down versus there's specific forms that
20 one has to complete for an investigative file
21 to be complete?

22 A. I don't know if there's so much
23 forms. It would depend on what the case would
24 dictate on it. You know, most of the time it's
25 actually reports that they are generating, a

1 written follow-up of --

2 Q. Sorry, I was going to sneeze.

3 A. It would be a follow-up on the
4 investigation, it would be what they've done to
5 either collect additional information,
6 collaborate -- corroborate the complaint and
7 what they're doing within their investigative
8 activity. So we don't have a specific form for
9 different things.

10 Now, we do have, you know, forms
11 within that for an error in dispensing. Let's
12 say they get -- we get a complaint involving an
13 error in dispensing, we have an error in
14 dispensing report that would be completed. So
15 there are some specific forms, but as for an
16 investigative in whole, most of the time it's
17 going to be more of a narrative form.

18 Q. What, if any, role does the board
19 have in the DEA setting of quotas for
20 prescription opioids?

21 A. None.

22 Q. Does the board stay abreast of
23 changes to quotas the DEA makes?

24 A. Not to my knowledge.

25 Q. The board does have available to

1 it the volume of prescription opioids that have
2 been dispensed in the state, correct?

3 A. Yes, in OARRS.

4 Q. And it can separate that out by
5 county, correct?

6 A. Yes, ma'am.

7 Q. Other than OARRS, is there any
8 other way that the board tracks the volume of
9 prescription opioids that are dispensed in the
10 state?

11 A. Can you give me an example of --

12 Q. Sure.

13 A. -- what other -- what you mean by
14 dispensed?

15 Q. Opioids that are transferred from
16 a licensed dispenser of controlled substances
17 to an individual.

18 A. Okay. So what would be that
19 example outside of a pharmacy?

20 Q. Is there self-reporting as opposed
21 to -- the OARRS data is -- and you can correct
22 me if I'm wrong. The pharmacist inputs the
23 data into a computer; it's automatically
24 uploaded into OARRS, correct?

25 A. Correct. A pharmacy, the support

1 staff, enter the prescription data into their
2 dispensing software, it's automatically pushed
3 to us on a daily basis. If you're asking if
4 there's other -- any other dispensings out
5 there other than what a pharmacy does --

6 Q. Right.

7 A. -- it would be a prescriber. They
8 are also required to record any dispensings of
9 controlled substances and/or gabapentin. I
10 can't think of another issue where an actual
11 dispensing is going on.

12 Q. If a vet gives 72 hours of some
13 opioid medication for someone's dog, there's no
14 -- they don't have to give -- there's no
15 prescription, right?

16 A. Well, that's an actual dispensing,
17 so that would be an order because the doctor is
18 doing it right there in their office, and they
19 do not have to report that to OARRS.

20 Q. So any licensed dispenser who is
21 dispensing less than 72 hours' worth of an
22 opioid medication doesn't have to report that
23 to OARRS?

24 A. No, a physician still needs to
25 report, but a veterinarian would not.

1 Q. Okay. What about a dentist? So
2 I'm getting a tooth pulled and the doctor gives
3 me 72 hours of hydrocodone, does he have to put
4 that in?

5 A. I believe they are required to
6 report also.

7 Q. But you don't know for sure?

8 A. I don't.

9 Q. In the case of an actual
10 physician, if she gives 72 hours' worth of some
11 drug for an in-and-out surgical procedure, does
12 she have to put that into OARRS?

13 A. They're required to report.

14 Q. But vets don't and we don't know
15 about dentists?

16 A. I believe dentists do.

17 Q. The OARRS data that's available to
18 the board also identifies the locations and
19 identities of specific dispensers, correct?

20 A. Yes.

21 Q. What does the board do with this
22 specific information, information that -- it's
23 got information about volume, dispenser,
24 location, and it's available at any given time,
25 is the board -- through OARRS.

1 Is the board routinely reviewing
2 that information?

3 A. That would be -- I'm not sure what
4 reports and what OARRS is doing with it. Ours
5 would be a request. If we were to review it in
6 compliance and enforcement, we would request a
7 certain type of report. Again, the proactive
8 reports that you discussed earlier, doctor
9 shopper, 640 list, those would be ones that are
10 automated. At some points in times if we would
11 identify an issue, a trend, what have you, we
12 may ask for them to do a different type of
13 report.

14 We've looked and compared overdose
15 death data in OARRS, how many of those
16 decedents had actual OARRS histories, different
17 things like that, so we have done some
18 different analysis. We've also looked at
19 different types of analysis with the data when
20 it comes to certain drugs that are prescribed
21 in addition to a secondary drug, or a certain
22 drug combination that would not be normal.

23 So, I mean, there's been numerous
24 different types that we've tried to look at the
25 data or we have looked at the data; I just

1 can't recall every type that we've done now.

2 Q. So the two proactive reports are
3 the 640 and the doctor shopper report, correct?

4 A. Correct.

5 Q. And those are the only two that
6 are -- as you put it, they're proactive
7 currently?

8 A. They're routinely sent to us in
9 compliance and enforcement, yes.

10 Q. You mentioned that you've looked
11 at overdose deaths -- overdose death data to
12 see who has an OARRS history, correct?

13 A. Uh-huh.

14 Q. How long ago did you do that?

15 A. We've compared that for the last
16 couple of years since we started getting the
17 information from the Health Department. We
18 didn't always have it readily available.

19 Q. And when did you start getting the
20 overdose death information?

21 A. Within the last couple years. Two
22 to three.

23 Q. And what, if anything, have you
24 noticed in comparing overdose death data with
25 who has an OARRS history?

1 A. The majority of them do have a
2 history in OARRS, which means they were
3 prescribed a controlled substance. I would say
4 the percentages are somewhere between 70 and 80
5 percent.

6 Q. And do you have available to you
7 the particular mechanism for overdose in that
8 data?

9 A. To tell what exactly the tox
10 screen said?

11 Q. Correct.

12 A. It's not going to be detailed
13 information. I do believe that OARRS has it to
14 some degree, but it's not as detailed as
15 actually getting the autopsy report.

16 Q. Do you get the autopsy report?

17 A. We do if we launch an
18 investigation.

19 Q. So as a regular -- in the regular
20 course, you're unable to tell from overdose --
21 comparing overdose data to an OARRS report
22 whether the prescription that --

23 A. That is in their history?

24 Q. Correct. Is the mechanism for the
25 overdose, correct?

1 A. No, you cannot tell that.

2 Q. So all you know is that 70 percent
3 of people whose overdose data you reviewed at
4 one point in time -- and it could be just one
5 point in time, had a prescription for a
6 controlled substance?

7 A. That is correct.

8 Q. Why did you do that comparison?

9 A. Because our overdose rates were
10 going up and we were trying to identify trends
11 and outliers in that prescriber community.

12 (Thereupon, Defendants' Exhibit
13 Number 5, Document: Ohio Governor's Office
14 Force Pharmacy Firing, was marked for purposes
15 of identification.)

16 BY MS. BROWNE:

17 Q. I'm going to hand you what has
18 been marked as Exhibit 5. This is -- Exhibit 5
19 is a September 16, 2014 AP article entitled
20 Ohio Governor's Office Forced Pharmacy Firing.
21 Do you see that?

22 A. I do.

23 Q. Have you seen this document
24 before, this -- in another form even, this
25 article?

1 A. I'm sure I have. I don't know if
2 it's this specific one. Let me read it real
3 quick.

4 Q. Sure.

5 (Pause in proceedings.)

6 MR. MORIARTY: And, I'm sorry, you
7 made this 5?

8 MS. BROWNE: Yes, I did.

9 THE WITNESS: Okay.

10 BY MS. BROWNE:

11 Q. Have you read this article or
12 articles like it?

13 A. I have.

14 Q. And this Exhibit 5 references the
15 parting of ways between Kyle Parker and the
16 Board of Pharmacy, correct?

17 A. Yes, ma'am.

18 Q. You were the director of
19 compliance and enforcement in 2014, September
20 1, 2014 when Mr. Parker stepped down, correct?

21 A. At the time when Kyle stepped down
22 I was the interim -- yes, I was the interim
23 executive director in charge of compliance and
24 enforcement.

25 Q. The article notes in the

1 penultimate paragraph, Ohio is in an all-out
2 war with opiates and pill mills, and the
3 executive director was sitting on his hands,
4 Nichols said. It was either indifference or
5 tone deafness, or he was being an
6 obstructionist, but either way, we wanted to
7 move the board in a new direction.

8 Did I read that correctly?

9 A. You did.

10 Q. What, if anything, was taking
11 place in 2014, from your perspective, that
12 indicated that Mr. Parker was not doing enough
13 to combat pill mills?

14 A. I'm not really sure of his
15 conversations with the Governor's office at
16 that point in time.

17 Q. Did you have an understanding that
18 Mr. Parker was pushed out?

19 A. I knew they wanted a change. I
20 don't -- I know the Governor's office wanted a
21 change and also the board had supported that
22 change.

23 Q. Who replaced Mr. Parker?

24 A. Mr. Steven Schierholt.

25 Q. Was there an interim before

1 Mr. Schierholt was appointed?

2 A. That was me.

3 Q. So was that from September through
4 December that you were the interim?

5 A. It may have been a two-month
6 period.

7 Q. A minute ago we were talking about
8 the comparison of overdose death data with
9 OARRS data and you mentioned that the majority
10 of those folks had some type of OARRS history
11 of the deaths that you reviewed; is that right?

12 A. Correct.

13 Q. Is the report comparing the death
14 rates to the OARRS history public?

15 A. I don't know.

16 Q. In what form did you review it?

17 A. It was reviewed and an analysis
18 summary was done by OARRS, either Chad or his
19 staff.

20 Q. How did you receive it?

21 A. I can't remember if it was via
22 email or not. Probably via email. But also
23 out of that report what we were looking for is
24 identifying the outlying prescribers.

25 Q. Was the purpose of this analysis

1 to identify the percentage of individuals who
2 had an OARRS history or to identify prescribing
3 outliers?

4 A. I think they're -- I think it was
5 more to look for the outliers; however, what we
6 realized when we first did the analysis was the
7 percentages.

8 Q. Who received this analysis?

9 A. Our board staff, our executive
10 director was aware of it, our chief of
11 compliance.

12 Q. Anybody else?

13 A. We've also worked with the medical
14 board and made referrals to them on some of the
15 physicians that were identified.

16 Q. So that report and analysis may
17 have been given to somebody on the medical
18 board?

19 A. I'm not sure if the entire
20 analysis was or just the parts for their
21 investigative purposes.

22 Q. The board has all of the
23 information it needs to discern possible
24 diversion, right?

25 A. No.

1 Q. What does it not have that it
2 needs in order to identify diversion?

3 A. Well, let's first identify what
4 setting we're talking in.

5 Q. Well --

6 A. Because every setting is
7 different.

8 Q. -- one of the -- one of the roles
9 of OARRS -- or, I beg your pardon, one of the
10 roles of the board is to identify diversion,
11 correct?

12 A. Absolutely.

13 Q. Okay. And, for example, the board
14 has OARRS available to it, right?

15 A. Uh-huh, yes.

16 Q. And the board, if it so chooses,
17 has ARCOS available to it, correct?

18 A. Yeah, but that would be more on a
19 case-specific basis.

20 Q. What, if anything else, does the
21 board need that it does not have in order to
22 fulfill its role in combatting diversion?

23 A. Well, I think that when you're
24 talking about -- when you're talking about at a
25 retail pharmacy, you don't have the on-hand

1 amounts within the system or any information
2 available to us on what their on-hand amounts
3 are. We would not have the on-hand amounts on
4 a hospital pharmacy. We would not be able to
5 identify a nurse theft occurring from a
6 specific patient or from a Pyxis machine with
7 any information that we have. We would not be
8 able to identify a theft at any type of EMS
9 location because there's nothing that they give
10 us a -- or provide us any type of inventories
11 on their drug boxes or on their drug
12 utilization.

13 We don't require an inventory be
14 submitted to the board. We require one be
15 taken and have it on hand, but we don't have
16 that piece of the puzzle.

17 Q. Has the board -- you mentioned
18 that one of the roles of the board is
19 development of rules and regulations, correct?

20 A. Yes, ma'am.

21 Q. Has there been any effort by the
22 board to develop some rule or regulation that
23 would provide it access to on-hand amounts at
24 pharmacies or hospital pharmacies?

25 A. You know, we did change the rate,

1 the inventory requirements in our rules. DEA
2 requires a two-year inventory, we moved it to a
3 one-year inventory. But again, it wasn't
4 reported to us, nor do I think that we would
5 have the -- it would be a technically
6 challenging undertaking.

7 Q. How so?

8 A. You would have to develop a new
9 system to catalog it, reporting it, everything
10 like that, and inventories change in a health
11 care setting by the minute. It would never be
12 accurate.

13 Q. So the board -- the board can't
14 accurately monitor for diversion in a hospital
15 pharmacy setting; is that right?

16 A. Via OARRS we could not.

17 Q. Is there any other way you can?

18 A. Inspection, proactive inspection.

19 Q. Do you believe -- does the board
20 believe that the proactive inspections that it
21 currently undertakes adequately addresses
22 potential diversion in the hospital setting?

23 A. I believe that the inspections do
24 address the recordkeeping and the security and
25 control. During a regulatory inspection,

1 they're addressed. If there's deficits in
2 those systems, the facilities are required to
3 give corrective actions to -- excuse me, to
4 those deficits and follow-up inspections are
5 scheduled and conducted.

6 Q. Is it your belief that those
7 proactive inspections are adequate to address
8 any potential diversion in the hospital
9 pharmacy setting?

10 A. Within the regulatory inspection
11 scope, yes.

12 Q. Is there some other scope?

13 A. There's only so much you can look
14 at when you're at an inspection, and again it's
15 a snapshot in time. So things can change when
16 you walk out the door.

17 Q. So a better way to adequately
18 monitor diversion in the hospital pharmacy
19 setting would be through access to on-hand
20 inventory amounts, correct?

21 A. No.

22 Q. Okay.

23 A. Again, your on-hand inventory is
24 going to change every time that a patient is
25 administered an injection, a pill, anything.

1 That on-hand inventory is a constant moving
2 number.

3 Q. And because the on-hand inventory
4 number is constantly moving, you cannot say
5 with certainty that the board is adequately
6 monitoring or preventing diversion in the
7 hospital pharmacy setting based solely on the
8 proactive inspections, correct?

9 A. Correct.

10 Q. How frequently are those proactive
11 inspections?

12 A. It depends. They're on a risk
13 schedule, so depending on -- the public risk or
14 the complexity of the pharmacy practice going
15 on at the facility depends on how frequent they
16 are inspected. Sterile compounders are a high
17 risk, they are on a yearly inspection - again,
18 these are unannounced, so they could be any
19 time - all the way down to a retail pharmacy is
20 at five years. I believe a hospital pharmacy
21 is at three years.

22 Q. And it's the board's belief that
23 it can adequately prevent diversion in a
24 hospital pharmacy setting based on a -- an
25 inspection that take place every three years?

1 A. You keep using the word
2 adequately. That's not my word.

3 Q. Okay.

4 A. What we do is we proactively
5 inspect to help prevent diversion. I don't
6 think there is an ultimate cure for diversion.
7 There's not going to be one thing that's going
8 to prevent all diversion because there's so
9 many different types and means in there. I
10 think it's one tool that we utilize to prevent
11 diversion, along with education of responsible
12 persons, along with investigations, along with
13 holding health care professionals responsible
14 for diversion. Those are all means of
15 prevention of diversion. There's no one magic
16 bullet.

17 Q. Exhibit 5 mentioned that one of
18 the reasons that Mr. Parker was pushed out was
19 an issue with pill mills, correct?

20 A. Yes.

21 Q. Were pill mills an issue in Ohio
22 prior to 2014?

23 A. Yes.

24 Q. Do you know when pill mills became
25 an issue -- I know we talked about the Florida,

1 but other than the prescriptions coming up
2 through Florida, were there other pill mill
3 issues in Ohio prior to 2014?

4 A. I believe so, and I think prior to
5 me there was pill mill issues. Prior to my
6 employment with the board I believe that there
7 was issues.

8 Q. So prior to 2008?

9 A. Yes, ma'am.

10 Q. Was Mr. Parker the executive
11 director when you joined --

12 A. No, ma'am.

13 Q. -- the BOP?

14 Who was the executive director
15 when you joined?

16 A. William Winsley.

17 Q. And he had the medical issue; is
18 that what you said?

19 A. No, no, the assistant executive
20 director at the time had a medical issue and
21 was on extended leave.

22 Q. Do you know why Mr. Winsley left?

23 A. I do not.

24 Q. Are you able to generally describe
25 the board's efforts from -- let's say from the

1 time you joined, so 2008 to the present, to
2 address opioid diversion?

3 A. Sure, yeah. So again, I think
4 that's a multi-bucket approach. Since I've
5 joined I'll just start with criminal, because
6 that's the majority of what I handled when I
7 first started, but we conducted numerous
8 investigations on those responsible for
9 diversion; and again, whether that's a doctor
10 shopper or whether that's a drug theft, whether
11 that's illegal processing, whether that's
12 trafficking in drugs, all the way to, you know,
13 the administrative investigations where
14 somebody potentially had -- was summarily
15 suspended, permanently revoked their license.
16 So I believe that us addressing the opiate
17 issue from a proactive law enforcement
18 standpoint was just one angle of how we
19 addressed prescription drug abuse.

20 We worked multiple investigations
21 collaboratively with state and local agencies,
22 FBI, IRS, DEA, HHS, OIG, local regulatory
23 boards or state regulatory boards, BWC,
24 Medicaid Fraud Control Unit.

25 Q. What is BWC?

1 A. Bureau of Workers' Compensation.

2 Q. Thank you. Go on, sir.

3 A. No problem. So from the criminal
4 and administrative investigative angle, we are
5 very proactive in our efforts.

6 I think, additionally, changing
7 the rules and essentially making legislative
8 requests for rule changes and law changes
9 helped strengthen our regulatory authority and
10 hold those more accountable, such as House Bill
11 93 2011, which essentially gave the board
12 authority to license pain management clinics.
13 It also set forth some rules that they had to
14 be physician-owned, that the prescriber could
15 only personally furnish 72 hours, and that the
16 -- and at that time it required the wholesalers
17 to now report all wholesale transactions to the
18 board.

19 And again, with other legislative
20 fixes that came after that, mandatory checking
21 of OARRS, the registration of technicians, to
22 the -- I'm trying to think of other rules that
23 went into place. Security and control rules,
24 we had some adjustments to those. All of these
25 types of rules, changes, I felt, helped us

1 combat the prescription drug issues that we
2 were seeing.

3 In addition to that, just the
4 massive amount of education we were trying to
5 get out there to our licensees, through our
6 newsletter, through our -- you can sign up for
7 board alerts on our website, all the way to
8 we've done -- I know we've done some webinars
9 in the past, and we do routine -- we've done
10 hundreds, literally, and continue to this day
11 of RP round tables, CE provided on law updates
12 and rule updates. We travel around to all the
13 pharmacy schools on a yearly basis and have
14 educational discussions with them and CE
15 programs with them. In addition, again, I
16 still think it's a bonus that you can call in
17 and talk to a live pharmacist at our agency and
18 ask questions.

19 On top of that, the enhancements
20 to OARRS. You know, one of the big drawbacks
21 was it takes too much time to log into the
22 system, and the integration has just changed
23 the whole scope of that. Putting it in the
24 workflow of a physician at their practice,
25 putting it into the front-line pharmacist that

1 is in that line making the dispensing, I think,
2 is key; in addition to the hospital systems
3 that it started in, you know, the integration
4 there, a patient hitting the ER and immediately
5 be able to have that OARRS report readily
6 available. I think it's drastically improved
7 as a clinical tool.

8 Adding the MED scores, changing
9 the NARx care to the NARx care platform for
10 prescribers, providing prescriber insight
11 reports. It's just -- it has evolved into a
12 very good tool for healthcare professionals.
13 And connecting the PMP with other PMPs, I
14 think, was another major accomplishment as
15 patients are very transient.

16 Q. You mentioned the rule and law
17 changes. Does the board have a lobbyist?

18 A. Cameron McNamee is our director of
19 communication. I believe he's registered as a
20 lobbyist. He helps draft the rules, along with
21 our chief pharmacist and input from the
22 compliance staff. And obviously the board has
23 insight and input into those also.

24 MS. BROWNE: Maybe we can take a
25 lunch break now because I'm going to get into

1 all the regs, which is kind of boring, so it's
2 perfect for right after lunch.

3 THE VIDEOGRAPHER: We're off the
4 record.

5 (Lunch recess taken.)

6 THE VIDEOGRAPHER: We're on the
7 record.

8 BY MS. BROWNE:

9 Q. Good afternoon, Mr. Griffin.

10 A. Good afternoon.

11 Q. I just wanted to clear up, before
12 we move on to the next topic, some of the stuff
13 that we talked about this morning.

14 We were discussing those
15 investigations in Cuyahoga and Summit and you
16 said during the five-year period or the
17 five-year lookback there were approximately 700
18 in Cuyahoga and approximately 231 from Summit.

19 Those were investigations that
20 were not confined just to opioids, right?

21 A. Correct, those were total
22 complaints.

23 Q. And the approximately two dozen
24 that you reviewed, were those opioid-specific?

25 A. Yes, but the two dozen I reviewed

1 were not specific in those counties. I was
2 looking for examples of opioid cases to those
3 two counties. So I was looking -- of the dozen
4 or so that I looked at, or two dozen I looked
5 at, I was looking for ones that specifically
6 had opiate-related in Cuyahoga and Summit
7 Counties. So all two dozen of those were not
8 from Cuyahoga or Summit.

9 Q. Understood. Thank you.

10 We also were talking a bit about
11 the inspections, some are annual, some are
12 every three years, some are every five years --

13 A. Yes, ma'am.

14 Q. -- and who does those inspections?

15 A. Our field staff complete those
16 inspections, so it's a combination of
17 compliance specialists, agents and inspectors.

18 Q. Is there a difference in level of
19 training between or among the compliance
20 specialists, the agents and the inspectors?

21 A. Yes, ma'am.

22 Q. What's --

23 A. Specialists are required to be
24 pharmacists, so they are licensed pharmacists
25 in the State of Ohio, and obviously have had

1 the training. They also have additional
2 training in sterile compounding and most come
3 with a diverse background between hospital and
4 retail experience.

5 Our agents are all -- come from a
6 law enforcement background or an investigative
7 background and our inspectors all come from an
8 industry background, such as technicians,
9 pharmacy technicians.

10 Q. And do the specialists, agents and
11 inspectors all receive any particular training
12 before they are deputized, if you will, to go
13 out and be Board of Pharmacy inspectors?

14 A. Yes, we have a 16-week orientation
15 program that all three go through where it --
16 it sort of diverges, if you will. At some
17 point during the 16 weeks it's additional
18 training where the specialists are with
19 specialists, the agents are with agents, and
20 the inspectors are with inspectors, and we call
21 that our field training program.

22 Q. The entire 16-week program is the
23 field training program?

24 A. Yeah. Or, I'm sorry, orientation
25 program.

1 Q. Is it always the same inspector
2 who visits a facility?

3 A. Not always. It can be, but not
4 always.

5 Q. What, if anything, determines who
6 will conduct the inspection at any given
7 facility?

8 A. They're all assigned geographic
9 regions and responsibilities for certain
10 license types; however, sometimes just with
11 overlap or a complaint, inspections may be
12 assigned to one inspector or agent or
13 specialist and another one ends up doing an
14 inspection in their territory or in their
15 region.

16 Q. So is it more frequently the case
17 that it's the same inspector visiting the same
18 facility?

19 A. Yes.

20 Q. And you mentioned it's by
21 geographic region and we talked a little bit
22 about your -- your regional supervisors, and
23 there's a Northeast Ohio, a Southeast Ohio, a
24 Southwest region and a Northwest region.

25 A. Yes, ma'am.

1 Q. Is there a specific map that you
2 guys -- that you at the board maintain that
3 shows which jurisdictions fall within each
4 region?

5 A. By county, yes. It's a State of
6 Ohio map that's divided into four quadrants.
7 So you can see the counties, but it doesn't
8 list like cities or townships. It just shows
9 the county for each region.

10 Q. Okay. Because we're in Columbus
11 in the middle of the state, right?

12 A. Uh-huh.

13 Q. So what region does that fall in?

14 A. Southeast Ohio. And the regions
15 are divided up -- the north and the south is
16 based upon the federal jurisdiction lines, the
17 Northern and Southern District U.S. courts.

18 Q. When we broke we were talking
19 about the efforts that the board has taken to
20 combat the opioid abuse and diversion issues
21 that we've been talking about today. Do you
22 remember that?

23 A. Yes, ma'am.

24 Q. And you talked about -- or you
25 mentioned that you work on formulating or

1 making requests for certain rule changes or
2 regulations, correct?

3 A. We work with our director of
4 communication for the drafting of the rules,
5 our chief pharmacist has input on all of the
6 rules, and also the compliance specialists are
7 sort of on an ad hoc type of group.

8 Q. Do you work with other local
9 agencies to create new legislation or rules or
10 regulations?

11 A. I would believe that Cameron has
12 conversations with other state agencies as to
13 our rules, especially the other regulatory
14 boards, just because so much of our rules and
15 licenses overlap with other prescriber boards.

16 Q. We had talked a little bit -
17 changing topics for a second here - about a 640
18 report; and volume alone isn't a determinative
19 factor in whether diversion is taking place,
20 right?

21 A. Correct.

22 Q. So you need to know -- you need to
23 know more than just there's 640 prescriptions
24 being written a month by a prescriber before
25 you can determine whether there's a diversion

1 issue, correct?

2 A. Correct. And it's not 640
3 prescriptions, it's 640 unique patients.

4 Q. I thought it was both.

5 A. Well, it would be, but you can't
6 just say prescriptions because one patient
7 could have three scripts and that would only be
8 one.

9 Q. Okay. So it's 640 prescriptions
10 or --

11 A. Not an or. 640 patients receiving
12 a new prescription.

13 Q. In a month?

14 A. In one month.

15 Q. What else do you need to know
16 other than volume to determine whether
17 diversion is taking place?

18 A. Volume of a prescriber?

19 Q. Yeah.

20 A. Well, that would -- you would have
21 to look at -- several other factors that you
22 would look at. You would look at any other red
23 flags, where is the patient population coming
24 from, how far are the patients traveling to see
25 the physician, what type of specialty they may

1 have. One of the red flags is whether they're
2 cash paying or accepting insurance. So there's
3 numerous different red flags that you would
4 have to look into other than just the volume
5 alone itself.

6 Q. You mentioned education as one of
7 the ways that the board works towards
8 prevention of abuse and diversion, correct?

9 A. Yes, ma'am.

10 Q. And part of that education effort
11 includes participation on various task forces?

12 A. I don't know if I said task force
13 as part of education. We do a lot of round
14 table events.

15 Q. But the board does participate in,
16 for example, the Governor's task force,
17 correct?

18 A. The opiate -- the GCOAT?

19 Q. Yes.

20 A. Yes, ma'am.

21 Q. And what is the purpose of that?

22 A. To provide guidance, give
23 information, update information on what's going
24 on with the pharmacy rule. Me personally, I
25 was on the LE work group.

1 Q. What is the LE work group?

2 A. Law enforcement work group.

3 Q. And what was the role of the law
4 enforcement work group?

5 A. Share information and talk about
6 different strategies and how different agencies
7 were dealing with different crises in their
8 community.

9 Q. So when you were talking about
10 education as one of the ways that the board
11 combats opioid abuse and diversion, you were
12 speaking about education of its licensees?

13 A. Yes. Well, no, not just our
14 licensees. We do OARRS for law enforcement
15 training, we have also done education with loss
16 prevention. So primarily our licensees, but
17 some other stakeholder education also.

18 Q. But not the general public?

19 A. I don't think we've offered
20 anything for the general public.

21 Q. Other than the GCOAT, is there --
22 are there any other task forces on which the
23 board participates directed towards opioid
24 abuse?

25 A. I would say we work with -- we

1 work with task forces, such as different DEA
2 tactical diversion squads, different drug task
3 forces across the State of Ohio. I'm not aware
4 of any task forces. I know that our executive
5 director sat on a working group with NABP, I've
6 sat on a working group with NABP in the past,
7 but no specific task forces.

8 MS. BROWNE: We'll mark as Exhibit
9 6 a copy of the Initial Report, Progress and
10 Recommendations, May 17th, 2010, Ohio
11 Prescription Drug Abuse Task Force.

12 (Thereupon, Defendants' Exhibit
13 Number 6, Ohio Prescription Drug Abuse Task
14 Force Initial Report Dated May 17, 2010, was
15 marked for purposes of identification.)

16 BY MS. BROWNE:

17 Q. Have you seen this document
18 before?

19 A. I have not.

20 Q. If you look on page 3 there's a
21 listing of task force members, and in the first
22 column, six down, it's William T. Winsley,
23 executive director, Ohio Pharmacy Board. Do
24 you see that?

25 A. Yes, ma'am.

1 Q. And we talked about Mr. Winsley
2 earlier today. He was the executive director
3 of the Board of Pharmacy back in 2010; is that
4 correct?

5 A. Yes, ma'am.

6 Q. The Ohio Prescription Drug Abuse
7 Task Force isn't GCOAT, right?

8 A. No, I don't believe so.

9 Q. If you turn to page 4 for me, this
10 -- of Exhibit 5 (sic), it's entitled the
11 problem - prescription drug abuse, and down at
12 the bottom one of the subtitles is reasons for
13 the increase.

14 Are you with me?

15 A. Yep.

16 Q. And the second sentence of that
17 section reads, while some of the legal reasons
18 include growth in overall prescription drug
19 use, direct marketing to consumers and general
20 over-prescribing, the most common illegal
21 reason is diversion.

22 Did I read that correctly?

23 A. You did.

24 Q. And you agree that, at least as of
25 2010, diversion was the greatest problem

1 regarding prescription drug abuse?

2 A. I'm not sure I understand the
3 problem. I think any type of drug abuse is a
4 problem. So your question is, is illegal
5 diversion the main problem?

6 Q. Well, the main reason, yes, for
7 the increase in prescription drug abuse.

8 A. I would say it has to be in
9 combination with over-prescribing.

10 Q. You can set that aside. Thank
11 you.

12 Do you happen to know who the
13 intended audience is of Exhibit 6?

14 A. I do not.

15 Q. Has GCOAT issued a report that you
16 know of?

17 A. I don't know.

18 Q. Do you participate on GCOAT?

19 A. I do not.

20 Q. But the board does?

21 A. Yes.

22 Q. Who from the board is the
23 participant?

24 A. I believe in the past it has been
25 Kyle Parker. I believe that Dr. John

1 Whittington, the assistant executive director,
2 participated, and I believe our current
3 executive director participates.

4 Q. And do you know if GCOAT has
5 issued any type of report at any point during
6 it's ten-year existence?

7 A. I don't know off the top of my
8 head.

9 Q. Do you know what the mission of
10 GCOAT is?

11 A. To help collaboratively find
12 solutions to help curb the opioid epidemic and
13 reduce unintentional overdose deaths.

14 Q. Going back to the ways in which
15 the board has worked towards combatting the
16 opioid epidemic, you mentioned that the board
17 works with -- with other regulatory -- is it
18 regulatory and -- well, let me back up.

19 It's state and local agencies, the
20 FBI, the IRS, OIG, HHS and DEA. Do you recall
21 that?

22 A. Yes, ma'am.

23 Q. And we talked a minute ago about
24 some work that Mr. McNamee does with other
25 regulatory boards, such as the medical board,

1 on legislation, right?

2 A. Yes, ma'am.

3 Q. Are there other efforts or
4 collaborations in which the board participates
5 with other state and local agencies?

6 A. Outside of investigations?

7 Q. Well, okay. So the investigations
8 which we talked about earlier today.

9 A. Right.

10 Q. We just talked about rule making
11 issues. Is there anything else?

12 A. Yeah, the prescription integrity
13 group with the Medicare -- excuse me, Medicaid
14 Fraud Control Unit, we collaborate with. Also,
15 that same unit hosts a quarterly meeting for
16 investigative units. Additionally, we've
17 hosted quarterly regulatory board meetings.

18 Q. What is the purpose of the
19 quarterly regulatory board meetings?

20 A. Discuss rule changes, law changes
21 with our different prospective licensee
22 population, discuss investigations.

23 Q. Who attends the quarterly
24 regulatory board meetings?

25 A. Nursing board, medical board,

1 pharmacy board, Medicare, Medicaid Fraud
2 Control Unit and dental board.

3 Q. But not licensees?

4 A. No.

5 Q. And the prescription integrity
6 group with Medicaid fraud, how often does that
7 --

8 A. I believe that's also quarterly.

9 Q. And who participates in those
10 meetings?

11 A. What agencies or what -- who from
12 our agency?

13 Q. First who from your agency.

14 A. A representative from OARRS and
15 Chief Pyles.

16 Q. And who from the other agencies?
17 What other agencies participate?

18 A. I know Medicaid is also present, I
19 know that the Attorney General's Medicaid Fraud
20 Control Unit is also there. I'm trying to
21 think who -- I'm not sure of the rest of the
22 agencies that participate in that one.

23 Q. And what is the purpose of the
24 meetings with the Medicaid Fraud Control Unit?

25 A. They're looking at trends in past

1 cases that they've -- that they've conducted
2 under investigation, similarities, and talking
3 about looking for information, I believe, in
4 the billing systems that is utilized.

5 Discussions center around those types of
6 things.

7 Q. Medicaid fraud -- the Medicaid
8 fraud unit has access to OARRS, doesn't it?

9 A. They can.

10 Q. You mentioned earlier that the
11 board also coordinates with the Bureau of
12 Workers' Compensation?

13 A. Yes, ma'am.

14 Q. What kind of coordination is that?

15 A. Criminal investigations mostly.

16 Q. Of patients?

17 A. Most times it's a prescriber.

18 Q. And you mentioned coordination
19 with the FBI, the IRS, OIG, HHS, DEA. We
20 talked a little bit this morning about
21 coordination with DEA.

22 Other than those -- the context of
23 criminal investigations, are there other
24 incidents -- or occasions when the board
25 coordinates with DEA?

1 A. Other than the investigation --

2 Q. Investigations.

3 A. Yeah. I mean, we've had
4 discussions about their rule changes over
5 times. We have an open dialogue, I would say,
6 with them on questions that they may have or we
7 may have of our prospective licensees.

8 Q. What coordination or collaboration
9 does the board have with HHS?

10 A. HHS/OIG is all in criminal
11 investigations.

12 Q. Is there anything about criminal
13 investigations involving the HHS/OIG that is
14 different from what we discussed this morning
15 about criminal investigations?

16 A. I'm not sure I understand the
17 question.

18 Q. Sure. So you said that the reason
19 that the board collaborates with HHS -- the OIG
20 of HHS is in criminal investigations, correct?

21 A. Correct, uh-huh.

22 Q. Earlier this morning we talked
23 about investigations that the board undertakes
24 with administrative and criminal, and that when
25 it conducts criminal investigations it does

1 factfinding and sort of the same type of
2 investigation and reporting that it would do
3 for an administrative proceeding, but that once
4 the factfinding is completed it gets referred
5 to a local prosecutor.

6 A. Or a U.S. prosecutor, yes.

7 Q. Or a U.S. prosecutor.

8 A. Yep.

9 Q. At what point does the OIG get
10 involved?

11 A. They may be at ground level. It
12 may be start to end, or if we find during our
13 investigation that there could potentially be a
14 Medicare fraud, we would contact them and they
15 would participate or have the option to
16 participate.

17 Q. In what manner is there
18 collaboration between the board and IRS?

19 A. Sure. So sometimes in drug
20 trafficking cases there's large amounts of
21 money that are not reported properly, taxes
22 paid on, and that there's violations of federal
23 IRS statutes, so we would coordinate with IRS
24 if we have anything like that; or vice-versa,
25 if they would have a pharmacy-related thing

1 they may call us.

2 Q. And lastly, you mentioned
3 coordination with the FBI. How does the board
4 coordinate with the FBI?

5 A. Sort of in the same manner with
6 DEA. FBI has a healthcare division, and so we
7 coordinate efforts with them so we're not
8 duplicating resources and investigative
9 efforts.

10 Q. Can you think of a recent time
11 when there was coordination with the FBI?

12 A. Yes, ma'am.

13 Q. When was that?

14 A. Within the last couple months;
15 however, the investigation is confidential.

16 Q. Understood. Can you tell me if
17 the investigation involves an individual as
18 opposed to a larger entity?

19 A. Both.

20 Q. You mentioned the coordination
21 with the regulatory boards. Does the board
22 ever coordinate with the department of alcohol
23 and abuse services?

24 A. We have on occasion. We have a --
25 recently we have a grant-funded position where

1 -- it's sort of an intervention where when we
2 run into those that are in need of treatment
3 and trying to hook them up with services or
4 trying to get them to services for counseling
5 or addiction.

6 Q. Is there any coordination with the
7 Department of Health?

8 A. Yes, ma'am.

9 Q. When?

10 A. Different types of investigation
11 where health has a regulatory authority, we
12 will notify them and coordinate with them. For
13 an example would be a contaminated drug product
14 at a hospital, we may coordinate our
15 investigative efforts, or something to that
16 effect.

17 Q. So the board would be involved in
18 the investigation of a contaminated drug
19 product?

20 A. Yes, ma'am.

21 Q. Why is that not a CDC function?

22 A. Because it comes from one of our
23 licensees at a sterile compounder. CDC would
24 also be involved, though, and potentially FDA
25 now.

1 Q. Are there any county level local
2 agencies with which the board will collaborate
3 or has collaborated?

4 A. We've -- you know, we've assisted
5 in collaboration with the Montgomery County
6 Drug Coalition and different sort of groups of
7 that effect around the state. The Ross County
8 also has a drug coalition that we participate
9 in. And so there's -- I think there's several
10 of those different types of smaller local level
11 involvement that the board has.

12 Q. You mentioned the collaboration,
13 particularly in the investigation context
14 between the DEA and the board --

15 A. Yes.

16 Q. -- and the sharing of information?

17 A. Yes, ma'am.

18 Q. There is information sharing with
19 FBI, IRS, HHS, during the -- during any of
20 these investigations, correct?

21 A. Yes, ma'am.

22 Q. And during the context of --
23 during an investigation, can a federal agency,
24 such as the FBI or the IRS, obtain the records
25 and documentation from the board?

1 A. Records and documentation of what?

2 Q. Of the investigation.

3 A. Do we exchange reports or give
4 them a report?

5 Q. Yeah.

6 A. Yes.

7 Q. Do you give them all of the
8 information? You know, for example, I'm not
9 saying do you just type up a report and give it
10 to the FBI. Are you under any obligation or do
11 you routinely give all of your information to
12 the FBI for them to sift through?

13 A. If we are conducting a joint
14 investigation, absolutely.

15 Q. I know that DEA and the FBI have
16 access to OARRS. What about the IRS?

17 A. If they're investigating a drug
18 crime, they could have access to it.

19 Q. And what about HHS?

20 A. Again, if they're investigating a
21 drug crime.

22 Q. How do you know when they access
23 OARRS or request access for OARRS that it's for
24 the investigation of a drug crime?

25 A. It's part of the -- my

1 understanding is it's part of the user
2 agreement and they have to put a unique case
3 number next to any inquiry that they make.

4 Q. You had mentioned that one of the
5 bills that you worked on that was -- when I say
6 you, I mean the board, that you guys -- that
7 the board was proud of is the 2011 House Bill
8 93, right?

9 A. We did have input on that and that
10 was some legislative requests by the board. I
11 don't know if I would use the word proud of,
12 but definitely it took significant moves to
13 give us more regulatory authority.

14 Q. And that gave you the authority to
15 license the pain -- to license pain management
16 clinics, correct?

17 A. Yes, ma'am, and it also added some
18 additional requirements of the pain management
19 clinics themselves.

20 Q. Including that they can only
21 dispense 72 hours' worth of controlled
22 substance?

23 A. Yes, ma'am.

24 Q. Were pain management clinics a
25 problem in Ohio in 2011?

1 A. I believe so.

2 Q. So what was the -- was that the
3 impetus for looking to pass that bill? What
4 brought that on?

5 A. I think that was one of the
6 reasons, through what we had learned through
7 investigations and different information that
8 we obtained, that we were seeing sort of the
9 mimic of the Florida pill mills, of cash-paying
10 physicians, cookie-cutter prescriptions, lines
11 out the door, different things like that in
12 clinics that were not owned by physicians or
13 ran by physicians.

14 Q. And selling prescription opioids
15 to individuals without a legitimate medical
16 purpose is a form of diversion, right?

17 A. Correct.

18 (Thereupon, Defendants' Exhibit
19 Number 7, Settlement Agreement with the State
20 Board of Pharmacy, Docket No. D-990726-009, was
21 marked for purposes of identification.)

22 BY MS. BROWNE:

23 Q. I'm going to mark as Exhibit 7 a
24 document bearing Summit_002052981 through
25 Summit_002052992. The heading is Imogene

1 Carole Maynard, R.Ph. (SA 04-03-2000) and it's
2 a Settlement Agreement with the State Board of
3 Pharmacy, docket number D-990726-009. Do you
4 see that?

5 A. I do.

6 Q. 1999 was before your time at the
7 board, correct?

8 A. Yes, ma'am.

9 Q. If you take a look at this
10 settlement agreement, Exhibit 7 --

11 A. Yes.

12 Q. -- it notes on page 1 through page
13 -- through page 11 of 12 -- well, no, I take
14 that back, through page 10 of 12, there's an
15 identification of -- there's 37 paragraphs'
16 worth of allegations or facts against
17 Ms. Maynard pertaining to failing to review
18 original prescriptions and/or refill
19 information, for over-utilization, incorrect
20 drug dosage and duration of drug treatment and
21 misuse.

22 For example, paragraph 5, sold
23 controlled substances to patient 1 without a
24 legitimate medical purpose and it lists
25 hydrocodone and Hydromet syrup. Paragraph 8,

1 she sold the following controlled substances to
2 patient 2 without a legitimate medical purpose
3 and it's Roxicet. Paragraph 9, she sold the
4 following controlled substances to paragraph 2
5 -- to patient 2 without a legitimate medical
6 purpose and it's hydrocodone. Do you see that?

7 A. I do.

8 Q. And then in paragraph 37 on page
9 10 of 12 it notes that Ms. Maynard pled guilty
10 --

11 Are you with me? I'm sorry.

12 A. Okay.

13 Q. Ms. Maynard pled guilty to two
14 counts of attempted illegal processing of drug
15 documents in violation of Section 2923.02 of
16 the ORC, misdemeanors in the first degree. Do
17 you see that?

18 A. Yes, ma'am.

19 Q. On page 11 of 12, paragraph (C) --
20 well, you can start with paragraph (B)
21 actually. Paragraph (B) notes that she must --
22 Ms. Maynard must successfully complete
23 jurisprudence examination offered by the board
24 prior to reinstatement, and if Ms. Maynard has
25 not successfully completed the jurisprudence

1 examination prior to one year from the
2 effective date of the agreement her license
3 will remain suspended until the condition has
4 been achieved. Do you see that?

5 A. I do.

6 Q. And then in paragraph (C) it notes
7 her license, upon the completion of the terms
8 of suspension and after having passed the
9 jurisprudence exam, will be issued
10 automatically upon renewal which may require
11 submission of continuing pharmacy education as
12 set forth in the OAC. Do you see that?

13 A. I do.

14 Q. So Ms. Maynard's license after a
15 year was to be reinstated, correct?

16 A. I would have to read through the
17 entire thing, but it -- from what you've read,
18 it sounds like after she completed her
19 jurisprudence -- if you come back up to (A), it
20 says that her license would be suspended for a
21 year.

22 Q. These offenses, if you tab through
23 this document, all took place between 1996 and
24 1997, correct?

25 A. I would have to read the document

1 to confirm that, but from the paragraphs that
2 you read they were, it looks like, dated all of
3 '96. I do see a couple paragraphs that
4 indicate a date -- a dispensing date of '97.

5 Q. OARRS was not available in 1996
6 and 1997, was it?

7 A. No, ma'am.

8 Q. But the board was able to conduct
9 an investigation to make these determinations,
10 correct?

11 A. I'm assuming they did.

12 (Thereupon, Defendants' Exhibit
13 Number 8, Order of the State Board of Pharmacy
14 vs. Charles A. Gilford, Docket No. 6-65-2, was
15 marked for purposes of identification.)

16 BY MS. BROWNE:

17 Q. I'm going to mark as Exhibit 8 a
18 document -- I'm sorry, this document does not
19 have any production numbers. I believe we
20 accessed this from the board website. And it's
21 the State Board of Pharmacy versus Charles A.
22 Gilford.

23 If you take a look at the first
24 paragraph, it notes that the State Board of
25 Pharmacy finds that Charles A. Gilford did sell

1 on more than one occasion between March 29,
2 1978 and December 13, 1979, without a valid
3 prescription, 26,600 tablets of Dilaudid 4
4 milligrams and 2,010 tablets of Quaalude 300
5 milligrams, of which both are Schedule II
6 controlled substances. Do you see that?

7 A. I do.

8 Q. Paragraph (2) notes the State
9 Board of Pharmacy finds that Charles A. Gilford
10 did sell biphedamine, Dilaudid and Percodan on
11 more than one occasion between July 21, 1978
12 and July 22, 1979 without a valid prescription.
13 Do you see that?

14 A. I do.

15 Q. And then the third paragraph,
16 Mr. Gilford did sell without a valid
17 prescription on more than one occasion between
18 July 10, 1978 and November 8, 1978 Desoxyn,
19 Parest, Tuinal and Seconal in amounts less than
20 the minimal bulk amount. Do you see that?

21 A. I do.

22 Q. And, finally, in paragraph (4), it
23 says the Board of Pharmacy finds that without a
24 written or oral prescription given by a
25 practitioner between May 16, 1978 and December

1 17, 1979, approximately 400 capsules of Tuinal
2 200 milligrams, approximately 430 capsules of
3 biphedamine 12 and approximately 10 capsules of
4 Eskatrol, all of which are Schedule II
5 controlled substances, correct?

6 A. Except for it's not 10 capsules,
7 it's 100.

8 Q. I stand corrected.

9 And on page 4 of this document the
10 board has determined to revoke Mr. Gilford's
11 pharmacist identification card, correct, in
12 paragraph (A)?

13 A. Yes, ma'am, that's what paragraph
14 (A) says.

15 Q. And paragraph (C), the board
16 denies Charles Gilford's application for a
17 Terminal Distributor of Dangerous Drugs
18 license, right?

19 A. Yes, ma'am.

20 Q. Do you have any knowledge as to
21 how the board was able to monitor prescription
22 and dispensing habits in the state?

23 A. When, now?

24 Q. In the 1970s.

25 A. No, ma'am.

1 Q. They didn't do it with OARRS,
2 though, right?

3 A. They did not do it with OARRS.

4 (Thereupon, Defendants' Exhibit
5 Number 9, Order of the State Board of Pharmacy
6 vs. Henry E. Agin, R.Ph., Docket No. 6-88-1,
7 was marked for purposes of identification.)
8 BY MS. BROWNE:

9 Q. We are going to mark as Exhibit
10 9 -- this is another printout from the Board of
11 Pharmacy website, State Board of Pharmacy
12 versus Henry E. Agin, registered pharmacist,
13 and there's an identification of findings of
14 fact.

15 Paragraph (1), on one or more
16 occasions between October 1st, 1982, Mr. Agin
17 did dispense without a valid prescription
18 approximately 1,508 tablets of Dilaudid 4
19 milligrams, correct?

20 A. Yes, ma'am.

21 Q. In paragraph (2) it notes that the
22 Board of Pharmacy finds that Mr. Agin, between
23 March 23, 1981 and February 25th, 1983, did
24 distribute by dispensing controlled substances
25 when he knew, or had reasonable cause to

1 believe, such drugs were intended for sale or
2 resale by another person and were not
3 prescribed for legitimate medical purposes by a
4 practitioner in the course of his professional
5 practice, to wit: approximately 360 tablets of
6 Percodan and approximately 300 capsules of
7 biphethamine 20 milligrams, both of which are
8 Schedule II controlled substances, and
9 approximately 200 tablets of Parabenzamine 43,
10 correct?

11 A. Yes, ma'am.

12 Q. Paragraph (3), between March 23,
13 1981 and February 25th, 1983, Mr. Agin
14 dispensed without a valid prescription
15 approximately 360 tablets of Percodan and
16 approximately 300 capsules of biphethamine,
17 correct?

18 A. Yes, ma'am.

19 Q. And it goes on, there's a couple
20 of things again in this 1983 period. Do you
21 see that?

22 A. I do.

23 Q. In paragraph (A) on the last page,
24 it notes that the Board of Pharmacy takes the
25 following actions: It suspended the registered

1 pharmacist's ID card of Mr. Agin for 24 months,
2 correct?

3 A. Yes, ma'am.

4 Q. There's then the two 24-month
5 suspensions shall run concurrently and they
6 will suspend 18 months of each 24-month
7 suspension on the condition that he takes and
8 successfully completes a jurisprudence exam
9 offered in January 1985, does not violate any
10 drug laws of the State of Ohio, any other state
11 or the federal government, and abides by the
12 Board of Pharmacy -- rules of the Board of
13 Pharmacy, correct?

14 A. Yes, ma'am.

15 Q. Every licensee of the Board of
16 Pharmacy has to not violate drug laws of the
17 State of Ohio, correct?

18 A. Correct.

19 Q. And every licensee of the state --
20 from the State Board of Pharmacy has to agree
21 to abide by the rules of the Board of Pharmacy,
22 right?

23 A. Yes, ma'am.

24 Q. Do all licensees have to take a
25 jurisprudence exam?

1 A. I believe that there is some law
2 component today of their CE requirement. I
3 don't know in 1985 what the requirement was.

4 Q. But what Exhibit 9 does
5 demonstrate is that, even in the 1980s, the
6 board was monitoring and disciplining
7 individuals who diverted prescriptions, right?

8 A. Yes, ma'am.

9 Q. And you would agree with me that
10 the conduct that is set forth in Exhibit 9 by
11 Mr. Agin is an example of diversion?

12 A. Yes, ma'am.

13 Q. And the conduct that we discussed
14 in Exhibit 8 with Mr. Gilford from the 1970s,
15 that's also diversion, correct?

16 A. Yes, ma'am.

17 Q. And even -- so even in the 1970s
18 the board was requiring its licensees to
19 recognize a legitimate medical purpose to --
20 prior to dispensing a medication, correct?

21 A. Yes, ma'am.

22 Q. Bear with me for a second.
23 You joined the board in 2008?

24 A. Yes, ma'am.

25 Q. Since you've been at the board, do

1 you know if any wholesale distributors have
2 been sanctioned?

3 A. Yes, ma'am.

4 Q. You do?

5 A. I do.

6 Q. Do you know if any of the
7 distributor defendants have been sanctioned?

8 A. I believe so.

9 Q. Do you know when?

10 A. I don't know when. And let me
11 correct my answer. Yes, I do know one of the
12 defendants has been sanctioned.

13 Q. How does the board determine
14 whether to accept an applicant's registration
15 as a Terminal Distributor of Dangerous Drugs?

16 A. It first goes through the
17 licensing process and they're required to
18 provide documentation, complete the application
19 process, and then seeing if there was no
20 issues; and depending on what type of license,
21 then it would be issued. Certain types of
22 licenses have to have a pre-inspection.

23 Q. What types of licenses have a
24 pre-inspection?

25 A. Pharmacy license, pain management

1 license, OBOT license.

2 Q. I'm sorry, what?

3 A. OBOT, office-based opioid
4 treatment facility.

5 Q. What is the difference between
6 that and a pain management clinic?

7 A. They treat two different types of
8 disease states. One treats pain and the other
9 one treats addiction.

10 Q. Any other different types of
11 licenses for TDDs?

12 A. Yes, high-risk sterile
13 compounders, and these are in-state TDDs, and
14 outsourcers.

15 Q. What is an outsourcer?

16 A. An outsourcer is essentially --
17 it's sort of tough to describe. So that's a
18 facility that complies with good manufacturing
19 practices set forth by the FDA, but is not a
20 full-blown manufacturing facility. They
21 normally produce smaller volumes and they may
22 do 503A or 503B, either wholesale sales or
23 patient-specific prescriptions.

24 Q. How is a patient-specific
25 prescription, the production of

1 patient-specific different from a compounding
2 pharmacy?

3 A. It's similar. They may have two
4 separate categories in their licenses.

5 (Thereupon, Defendants' Exhibit
6 Number 10, Minutes of the June 9-10, 2014
7 Meeting of the Ohio State Board of Pharmacy,
8 was marked for purposes of identification.)

9 BY MS. BROWNE:

10 Q. I'm going to mark as Exhibit 10
11 the Minutes of the June 9 to 10, 2014 Meeting
12 of the Ohio State Board of Pharmacy. It's
13 marked with production identification
14 OhioPharmMins_000106. And if you would turn
15 for me to the page - the top right are the page
16 numbers - to page 247.

17 Are you with me?

18 A. Yes, ma'am.

19 Q. The entry is R-2014-231 and it's a
20 settlement agreement with the State Board of
21 Pharmacy, case number 2012-1918, Pharmacy
22 Creations, care of Scott Karolychyk, in
23 Randolph, New Jersey. Do you see that?

24 A. Yes, ma'am.

25 Q. And on page 248 in paragraph

1 number (2), it notes, to wit: the applicant
2 did, on or before October 10th, 2012, illegally
3 compound and sell dangerous drugs to Valley
4 Surgical Center in Ohio without being licensed
5 as a Terminal Distributor of Dangerous Drugs.

6 Did I read that correctly?

7 A. Yes, ma'am.

8 Q. And page 248 also notes at the top
9 in the first whereas clause that the State
10 Board of Pharmacy is empowered to suspend,
11 revoke, refuse to renew any license issued to a
12 Terminal Distributor of Dangerous Drugs
13 pursuant to Section 4729.54 of the Revised
14 Code, or may impose a monetary penalty on the
15 license holder, correct?

16 A. Yes, ma'am.

17 Q. And paragraph (3) notes that
18 specifically the applicant did, on or before
19 October 10th, 2012, sell compounded drugs to
20 Valley Surgery Center in a quantity exceeding a
21 72-hour supply, correct?

22 A. Yes, ma'am.

23 Q. It looks like these were
24 vancomycin and other antibiotics, correct?

25 A. That's what it appears. I would

1 have to look up each of the drug chemicals that
2 they have listed.

3 Q. And as a penalty, if you turn to
4 page 249 of this, it notes that the pharmacy
5 had to pay \$2,000, that it is granted its
6 license as a TDDD, but is on probation for a
7 year, correct?

8 A. Yes, ma'am.

9 Q. And the terms of the probation are
10 that the pharmacy must not violate the drug
11 laws of the State of Ohio or any other state or
12 the federal government, correct?

13 A. Yes, ma'am.

14 Q. The pharmacy must abide by the
15 rules of the State of Ohio Board of Pharmacy,
16 correct?

17 A. Correct.

18 Q. And it must comply with the terms
19 of this agreement, correct?

20 A. Yes, ma'am.

21 Q. And as we discussed, any licensee
22 has to agree not to violate the drug laws of
23 the State of Ohio, any other state or the
24 federal government in the normal course of
25 things, correct?

1 A. You would expect so, yes.

2 Q. And any licensee of the State
3 Board of Pharmacy also must agree to abide by
4 the rules, correct?

5 A. Yes.

6 Q. Is there a standard by which the
7 board determines whether to revoke or suspend a
8 TDDD's license?

9 A. I don't know of a standard. The
10 board is a tribunal essentially that hears the
11 facts of the case and makes a decision and a
12 recommendation and a ruling.

13 Q. Are all licensees that may be
14 subject to revocation or suspension entitled to
15 a formal hearing?

16 A. Yes.

17 Q. Do you know how often a TDDD's
18 license has been suspended in 2019?

19 A. In the last month, I'm not sure
20 we've had any suspended in the last month.

21 Q. What about 2018, any suspended in
22 2018?

23 A. I'm sure we have. I don't know
24 them off the top of my head, but I'm sure we
25 have.

1 Q. Do you recall if any have been
2 revoked, any licenses have been revoked in
3 2018?

4 A. Again, I don't know off the top of
5 my head. I would assume that we have.

6 MS. BROWNE: We need to take a
7 break so you can change the DVD.

8 THE VIDEOGRAPHER: We're off the
9 record.

10 (Recess taken.)

11 THE VIDEOGRAPHER: We're on the
12 record.

13 BY MS. BROWNE:

14 Q. Mr. Griffin, we -- can you pull
15 out Exhibit 7 for me again? That's the Imogene
16 Carole Maynard settlement agreement.

17 A. Yes, ma'am.

18 Q. At the bottom of the first page of
19 Exhibit 7, that paragraph (2) --

20 A. I'm sorry.

21 Q. Sure.

22 A. Paragraph (2).

23 Q. Paragraph (2), numbered (2) at the
24 bottom of the page, there's this reference to
25 failing to review the original prescriptions

1 and/or refill information for over-utilization.

2 Do you have an understanding of
3 what the term over-utilization means?

4 A. I do.

5 Q. What is that?

6 A. Overlapping therapies or a drug
7 therapy that would be contraindicated by a
8 disease state or by manufacturer guidelines.

9 Q. Is over-utilization also another
10 word for over-prescribing?

11 A. It could be, but not one and the
12 same.

13 Q. So is over-utilization a type of
14 over-prescribing?

15 A. No, I wouldn't categorize that. I
16 would say that over-utilization could be -- if
17 a disease state called for a certain regimen or
18 a certain length of duration that you would
19 take a specific drug and the pharmacist
20 dispensed way over that amount, I would say
21 that would be an over-utilization, but not
22 maybe an over-prescribing.

23 Q. But they both involve giving too
24 much medication for --

25 A. They do, yes.

1 Q. Okay, so let me start over. They
2 both involve giving too much medication for a
3 particular disease state, but you don't equate
4 the two? Is it because over-utilization is
5 broader than over-prescribing?

6 A. I believe so.

7 Q. Okay. So over-prescribing may be
8 an example of over-utilization?

9 A. Could be.

10 Q. You can put that aside.

11 So we've seen a couple of these
12 settlement agreements where a fine has been
13 levied or a license has been suspended.

14 What other types of discipline are
15 available to the board?

16 A. There can be additional CE
17 requirements. I know you saw jurisprudence in
18 there; however, there could be other different
19 types of CE requirements. They can be on
20 probation and have to appear before a
21 probationary committee. Other than their
22 suspension, there's permanent revocation.

23 Additionally, with impairment
24 cases they may be required to enter into an
25 agreement with a monitoring agency or a type of

1 company or association to monitor their
2 compliance with a drug treatment plan. They
3 may also have to report -- submit quarterly
4 reports or different types of reports deemed
5 necessary by the board.

6 Q. What kind of quarterly reports?
7 What would that entail?

8 A. Whether it's their drug screens,
9 whether it would be inventories. We've had
10 incidences where they've had to have consultant
11 pharmacists review different policies and
12 procedures.

13 Q. You mentioned earlier that in 2018
14 one of the defendant wholesalers -- I beg your
15 pardon, distributors had been sanctioned.
16 Which distributor was that?

17 A. I didn't know if it was that
18 specific year, but Cardinal had been sanctioned
19 by the board. I don't recall that I said 2018.

20 Q. You're right. It was since you
21 joined, so since 2008?

22 A. In 2008 Cardinal was disciplined
23 by the board and we've had a couple others
24 since then.

25 (Thereupon, Defendants' Exhibit

1 Number 11, Minutes of the September 13-15, 2010
2 Meeting of the Ohio State Board of Pharmacy,
3 was marked for purposes of identification.)

4 BY MS. BROWNE:

5 Q. I'm handing you what has been
6 marked as Exhibit 11. Exhibit 11 is the
7 minutes of the June 9 to 10 --

8 Do I have that right?

9 A. This looks like September.

10 Q. You're right, I'm looking at the
11 wrong one. I beg your pardon. This is the
12 meeting -- you're right, the meeting minutes
13 from September 13 to 15, 2010 of the Ohio State
14 Board of Pharmacy. Do you see that?

15 A. Yes, ma'am.

16 Q. It bears a production at the
17 bottom OhioPharmMins_00044?

18 A. Yes, ma'am.

19 Q. If you could please turn to the --
20 it's the fourth page that starts at the top
21 R-2011-057, settlement agreement with the State
22 Board of Pharmacy, docket number D-100617-131
23 in the matter of Marc's, M-A-R-C, apostrophe S,
24 Pharmacy, number 46. Do you see that?

25 A. Yes, ma'am.

1 Q. And it notes in paragraph (1) down
2 towards the bottom of the page that Marc's
3 Pharmacy is licensed as a Terminal Distributor
4 of Dangerous Drugs, correct?

5 A. Yes.

6 Q. And then in paragraph (2) it notes
7 that Marc's Pharmacy, on or about November
8 11th, 2009, did not have adequate safeguards,
9 and notes specifically procedures were not in
10 place, and/or procedures were not followed, so
11 as to prevent drugs that had been dispensed
12 from being sold, slash, delivered to persons
13 other than the correct patient. Rx 158371,
14 written for metoprolol 25 milligrams, and Rx
15 162105, written for Seroquel 50 milligrams,
16 were prescribed and dispensed for patient X,
17 but was given to patient Y, who had actually
18 been prescribed Rx 464562, written for
19 Synthroid 100 micrograms. Patient Y ingested
20 the incorrect medication and was harmed.

21 Did I read that correctly?

22 A. Yes.

23 Q. Are the facts that I just read an
24 example of diversion?

25 A. It could be; however, this would

1 be more indicative of an error in dispensing.

2 Q. Noted in paragraph (A), it says
3 Marc's Pharmacy agrees to the imposition of a
4 monetary penalty of \$500, correct?

5 A. Yes, ma'am.

6 Q. Is \$500 a typical amount for an
7 error in dispensing?

8 A. I'm not exactly sure. It sounds
9 like it could be.

10 Q. Is there some matrix or
11 identification of -- within the board as to
12 amounts that certain violations would require
13 as an appropriate form of punishment or
14 discipline?

15 A. I know that we've worked on
16 something to that effect; however, I don't know
17 if it's been implemented.

18 Q. But at least as -- as of 2010, to
19 your knowledge there was no matrix or standard
20 amount of penalty that corresponded to a
21 specific violation?

22 A. No, ma'am.

23 (Thereupon, Defendants' Exhibit
24 Number 12, Minutes of the December 1-3, 2014
25 Meeting of the Ohio State Board of Pharmacy,

1 was marked for purposes of identification.)

2 BY MS. BROWNE:

3 Q. We've marked as Exhibit 12 the
4 Minutes of the December 1st through 3rd, 2014
5 Meeting of the Ohio State Board of Pharmacy.
6 You were present, right, if you look at that
7 third paragraph, Eric Griffin, compliance and
8 enforcement supervisor?

9 A. Yes, ma'am.

10 Q. If you turn, again, there's page
11 numbers on the top right, to page 201 of
12 Exhibit 12. At the bottom of the page is a
13 settlement agreement with the State Board of
14 Pharmacy, case number 2013-1696, Heritage
15 Healthcare, dba Heritage Pharmaceutical &
16 Medical Supplies, care of John L. Hunter,
17 registered pharmacist. Do you see that?

18 A. I do.

19 Q. Have you seen these minutes
20 before?

21 A. I don't approve the minutes. I
22 don't know if I've seen these particular
23 minutes in the past.

24 Q. If you turn to page 202, at the
25 bottom of the page is paragraph (2), and it

1 notes that, specifically, Heritage had no
2 system in place to verify the signature of Life
3 Ambulance's responsible person Dr. Wayne
4 Wheeler. This lack of security and control
5 over the process of dangerous drug orders
6 allowed Life Ambulance employee, Brian Buckle,
7 an individual with a known history of drug
8 abuse, to sign DEA 222 forms for controlled
9 substances on behalf of Life Ambulance as
10 evidenced by the DEA 222 forms dated June 14,
11 2013 and July 5, 2013, with attached packing
12 slip invoices.

13 Did I read that correctly?

14 A. You did.

15 Q. And paragraph (3) notes that on or
16 about November 12th, 2012 through September
17 2013, Heritage failed to detect the fraudulent
18 orders for controlled substances and other
19 dangerous drugs that were being placed by Life
20 Ambulance employee, Brian Buckle, for his own
21 self-administration.

22 Did I read that correctly?

23 A. You did.

24 Q. Is this an example of diversion?

25 A. It is.

1 Q. And in this case Heritage had
2 failed to detect fraudulent orders for
3 controlled substances that were being placed by
4 this ambulance employee, correct?

5 A. Yes, ma'am.

6 Q. We talked a little bit earlier
7 about the pharmacy's -- I beg your pardon, the
8 board's having imperfect control over
9 ambulances because of the constant changing of
10 the inventory in order to prevent diversion?

11 A. I think it's not just EMS, but I
12 would say most licensed sites where they're
13 administering on a continual basis, yes, ma'am.

14 Q. And in this case Heritage paid
15 \$5,000. Do you see that, paragraph (A)?

16 A. I do.

17 Q. As of 2015, do you have an
18 understanding as to whether a diversion
19 violation such as this -- whether -- strike
20 that. Whether a \$5,000 fine was typical for a
21 diversion violation such as this?

22 A. I don't have knowledge of that. I
23 don't know if that would be typical or not.

24 Q. Okay. You can set that aside.
25 Does the board have in place

1 policies or procedures for responding to
2 suspicious order reports that are submitted by
3 distributors?

4 A. We do not have a written policy or
5 procedure; however, they are reviewed
6 periodically by a supervisor, and the most
7 recent system set up will review them at the
8 weekly intake meetings where we also review the
9 complaints.

10 Q. Does a suspicious order report
11 automatically trigger an investigation?

12 A. No, ma'am.

13 Q. In what circumstances would there
14 not be an investigation?

15 A. Well, to give you an example, the
16 majority of our suspicious order reports are
17 for package sizes less than a quantity of four.
18 I think roughly 75 percent are for a package
19 size less than four and you need additional
20 information from the wholesalers. We've
21 requested additional information in the past
22 and we've also opened an investigation based
23 upon some suspicious orders in the past.

24 Q. So what does trigger an
25 investigation?

1 A. It would have to be after
2 gathering information where the order has
3 additional information other than just a
4 suspicious order report, why does the
5 wholesaler or the drug distributor feel that it
6 is a suspicious order; such as, you know, it
7 deviates from regular buying power -- or
8 regular buying pattern, sorry, not power, and
9 that -- essentially why it was suspicious. The
10 majority of our suspicious orders are one and
11 two bottles to normal pharmacies that don't
12 raise a red flag.

13 Q. What do you mean by a normal
14 pharmacy?

15 A. A chain pharmacy.

16 Q. And chain pharmacies don't
17 regularly raise a red flag?

18 A. No, they absolutely can, but they
19 also do the highest volume in the state.

20 Q. So they tend to be more trusted?

21 A. I would not say that. I would
22 just say that we know that they dispense a lot
23 more medication than other pharmacies do.

24 Q. So you mentioned if there is a
25 deviation in a regular buying pattern, that

1 might trigger an investigation, right?

2 A. However, we would need that
3 information from the wholesaler.

4 Q. What if you see repeated reports?

5 A. We would contact the wholesaler
6 and ask them for additional information;
7 however, if the wholesaler -- the first
8 question is if you're seeing repeated reports,
9 why is the wholesaler continuing to sell to
10 them, so we would probably ask that question
11 and we would ask for additional information.

12 Some of the -- from the policies
13 and procedures that we've learned, some of the
14 suspicious order reports are solely based upon
15 a number verse an actual knowing the customer's
16 business model, and so they could go two
17 tablets over and it would generate a suspicious
18 order report.

19 (Thereupon, Defendants' Exhibit
20 Number 13, Fax Dated April 21, 2016 with
21 attached Suspicious Order Report, was marked
22 for purposes of identification.)

23 BY MS. BROWNE:

24 Q. We're going to mark as Exhibit 13
25 a document parked BOP_MDL 2nd production 00105

1 to 106. This is a two-page fax. The date at
2 the top is April 21st, 2016 and the title is
3 Suspicious Order Report. Do you see that?

4 A. I do.

5 Q. On the second page of Exhibit 13
6 it's a Cardinal Health Memo to the Board of
7 Pharmacy, South High Street, Columbus, Ohio.
8 That's your Board of Pharmacy, correct?

9 A. Yes, ma'am.

10 Q. And this is a suspicious order
11 report for the Ritzman Pharmacy in Akron,
12 correct?

13 A. Yes, ma'am.

14 Q. Do you recall how, if at all, the
15 board responded to this suspicious order
16 report?

17 A. I don't recall.

18 Q. Do you know if the board has
19 received other suspicious order reports from
20 Ritzman Pharmacy?

21 A. I can't recall off the top of my
22 head.

23 Q. You mentioned that if there were a
24 number of suspicious order reports over a given
25 time you would wonder why the wholesaler was

1 still sending medication to that pharmacy,
2 right?

3 A. Correct.

4 Q. But pharmacies obtain
5 pharmaceuticals from multiple wholesalers,
6 don't they?

7 A. They can.

8 Q. So you could have multiple
9 suspicious order reports about, for example,
10 the Ritzman Pharmacy, from more than just
11 Cardinal, correct?

12 A. You could.

13 Q. And what point, if at all, would
14 you elevate that to an investigation?

15 A. We would have to glean more
16 information from either of the wholesalers to
17 find out why. It is not uncommon for any
18 pharmacy to have multiple wholesalers. They
19 normally have a primary and a secondary
20 wholesaler.

21 Q. And if that pharmacy received
22 multiple suspicious order reports or you
23 received multiple suspicious order reports
24 regarding one pharmacy, that does not
25 automatically trigger an investigation?

1 A. It would not because you don't --
2 we don't know why the wholesaler is triggering
3 it. You would have to find out from them what
4 their suspicious order report policy and
5 procedure is. We've had discussions with
6 Cardinal in the past, you know, and sometimes
7 with different wholesalers, and the fact that,
8 again, it could just be a number that they've
9 generated and the system automatically
10 calculates or sends a suspicious order report,
11 when in theory it's legitimate use.

12 Q. So, for example, Cardinal has a
13 suspicious monitoring -- let's take Cardinal
14 out of it. A wholesaler has a suspicious
15 monitoring software that, based on numbers,
16 will automatically generate a suspicious order
17 report?

18 A. Right.

19 Q. But it's not numbers alone. What
20 you're saying is that just because there's a
21 suspicious order report doesn't necessarily
22 mean it really is a suspicious order?

23 A. Correct.

24 Q. Because you can't tell just based
25 on the numbers --

1 A. We can't tell just by this
2 document that this is a suspicious order.

3 Q. Are the requirements for
4 investigating a suspicious order codified
5 anywhere?

6 A. No, ma'am.

7 Q. We've talked a little bit about
8 new rules and regulations and the board's role
9 in proposing or passing various rules,
10 regulations and legislation, correct?

11 A. Yes, ma'am.

12 (Thereupon, Defendants' Exhibit
13 Number 14, State of Ohio Board of Pharmacy 3rd
14 Quarter 2017 - Rule Update, was marked for
15 purposes of identification.)

16 BY MS. BROWNE:

17 Q. We'll mark as Exhibit 15 -- I beg
18 your pardon, Exhibit 14 a printout from the BOP
19 website. It's entitled 3rd Quarter 2017 - Rule
20 Update.

21 A. Yes, ma'am.

22 Q. And it notes some of the rules
23 effective this quarter are organized into these
24 new divisions; for the rules that are
25 rescinded, please refer to the last column to

1 see if the rule has been moved to a new
2 division, correct?

3 A. Yes, ma'am.

4 Q. Are you able to tell me by just
5 paging through this document which, if any, of
6 these rules may have been enacted in response
7 to the opioid crisis?

8 A. I can't tell you specifically
9 which ones; however, on some of the amendments
10 what I can tell you is that manner of issuance
11 could have an amendment to help strengthen the
12 rules, definitions of impairment --

13 Q. Let me stop you right there. I'm
14 sorry. So manner of issuance is Rule
15 4729-5-30?

16 A. Yes, ma'am.

17 Q. Go on. Sorry.

18 A. So the amendment to that rule
19 could have had some impact or response to the
20 opiate. The definitions of impairment and
21 summary suspension, I think we had added
22 language in that section. I think we also had
23 added some security requirements, which was
24 47-9-05. I'm not sure about the electronic
25 format required for transmission of dispensing

1 data. I think that may have been the change
2 that also went along with manner of issuance
3 for possibly requiring ICD-10 codes.

4 Q. And what reg number or rule number
5 was that?

6 A. 4729-37-05.

7 Q. Anything else?

8 A. Not that I see at this time. This
9 is more of an update because we were moving the
10 sections.

11 Q. Is this the most recent update to
12 the rules and regulations from the board?

13 A. No, ma'am.

14 Q. When was the most recent update?

15 A. We have some going into effect
16 April 15th of this year.

17 Q. And are any of the rules that are
18 going into effect on April 15th of 2019
19 directed to combatting the opioid crisis?

20 A. I don't think any one single rule
21 is the combatting opioid rule. I think they
22 collectively together help strengthen our
23 ability to hold licensees accountable, and I
24 would say yes with that rule.

25 Q. Are the rules that are going into

1 effect or under consideration by the board at
2 this time primarily concerned with medical
3 marijuana?

4 A. No.

5 Q. You mentioned that when you
6 receive a suspicious order report similar to
7 what we looked at in Exhibit 13, they can be
8 reviewed at weekly status -- or weekly intake
9 meetings.

10 Are suspicious order reports ever
11 discussed with any federal, state or local
12 entity?

13 A. They could be as part of an
14 investigation.

15 Q. So the only -- but the only time
16 that you would discuss, you, the board, would
17 discuss a suspicious order report with another
18 agency would be if it is elevated to an
19 investigation?

20 A. Yes, ma'am.

21 Q. And the entities or the agencies
22 with whom you would interface on the
23 investigation are the ones we've already talked
24 about, perhaps other regulatory boards, like
25 medical or veterinarian or dental or the

1 federal law enforcement agencies?

2 A. Or state -- or local law
3 enforcement agencies.

4 Q. Has the board issued any guidance
5 to wholesale drug distributors regarding the
6 reporting of suspicious orders?

7 A. Not that I can recall. You're
8 specifically talking about wholesale?

9 Q. I'm going to get to others, but I
10 need to do it one at a time.

11 A. Okay, sorry. Wholesale, not that
12 I can recall, any specific guidance for the
13 wholesalers.

14 Q. To other distributors has the
15 board issued any guidance as to the reporting
16 of suspicious orders?

17 A. Can you ask that question again?

18 Q. I'm sorry, that was a bad
19 question.

20 So to TDDDs, have there been any
21 guidance given -- has there been any guidance
22 given with respect to suspicious order
23 monitoring?

24 A. No, ma'am.

25 Q. OAC 4729-9-16 is the code

1 provision that pertains to the reporting of
2 suspicious orders, correct?

3 A. Okay.

4 Q. Is that right? Do you know that?

5 A. I don't know it off the top of my
6 head.

7 Q. Fair enough.

8 A. If you had a copy of it --

9 Q. I'll see if I have a copy of it.

10 A. -- I could verify it.

11 Q. Okay.

12 A. I believe it is.

13 Q. Okay. Let's take a look at
14 Exhibit E, please. Pardon me, tab U. I beg
15 your pardon.

16 (Thereupon, Defendants' Exhibit
17 Number 15, Minutes of the December 8-9, 2008
18 Meeting of the Ohio State Board of Pharmacy,
19 was marked for purposes of identification.)

20 BY MS. BROWNE:

21 Q. Exhibit 16 (sic) is the Minutes of
22 the December 8th through 9th, 2008 Ohio State
23 Board of Pharmacy Meeting. Do you see that?

24 A. Yes, ma'am.

25 Q. If you -- it's bearing production

1 OhioPharmMins_16, and there are no page
2 numbers, so about ten pages in -- I think you
3 just passed it. Ten pages in is the -- sets
4 out 4729-9-16, minimum requirements for
5 wholesalers. Do you see that?

6 A. Yes, ma'am.

7 Q. And this reg is a number of pages,
8 but just generally is it your understanding
9 that this code provision includes the
10 requirements for wholesalers to report
11 suspicious orders?

12 And I'll give you a hint,
13 paragraph H(1)(e) applies to suspicious orders.

14 A. Yes, ma'am.

15 Q. These regs are reported in the
16 2008 minutes of the Board of Pharmacy. Do you
17 know if this provision has been updated since
18 2008?

19 A. I don't know. I know it's -- a
20 new provision will be effective April 15th of
21 these rules.

22 Q. So a new provision of 4729-9-16 is
23 going to become effective as of April 15th,
24 2019?

25 A. Yes, ma'am.

1 Q. Do you know if the provision
2 related to suspicious orders specifically, so
3 in this reg it's paragraph H(1)(e), is going to
4 change at all?

5 A. Yes, ma'am.

6 Q. Do you know how?

7 A. Yeah. So there will be a
8 requirement for the wholesalers to report if
9 they cut off a company, they must do due
10 diligence on knowing the customer and the fact
11 of not so much their specific business model,
12 but knowing, you know, are they a cash entity
13 business, different types of indicators or due
14 diligent requirement for the wholesalers.

15 Q. If you turn to page 1 of Exhibit
16 14 (sic), it notes that these rules that we are
17 looking at were made effective as of January
18 1st, 2009. Do you see that? It's at the very
19 bottom of the page, R-2009-124, Mrs. Gregg
20 moved that the rules be approved?

21 A. Okay. Yes, ma'am.

22 Q. Since January 1, 2009, do you know
23 if there has been any guidance given to
24 wholesale drug distributors about this
25 provision 4729-9-16 by the board?

1 A. I don't know.

2 Q. You don't know one way or the
3 other?

4 A. I don't.

5 Q. Who would know that?

6 A. Since 2009, it could be
7 Mr. Winsley, it could be Mr. Parker, or
8 Mr. Keeley as he was the one that was -- it
9 looks like presented the rules.

10 Q. Would Mr. McNamee know?

11 A. I don't know. He was -- I don't
12 know when he started with the board, but he
13 hasn't been here that long.

14 Q. You can set that aside.

15 So we've just talked a little bit
16 about requirements of wholesale distributors,
17 at least with respect to suspicious ordering.

18 Do you have an understanding as to
19 the professional obligations of pharmacists who
20 are authorized by the board to dispense
21 prescription opioid medications?

22 A. I do.

23 Q. And what are those?

24 A. They have to perform the
25 prospective drug utilization that's spelled

1 out, which includes ensuring that there is not
2 over-utilization, the prescription is issued
3 for a legitimate medical purpose. They must do
4 a DUR on that, making sure there's no drug
5 interactions. In some incidences they would be
6 required to check OARRS. And then there has to
7 be -- obviously under the manner of issuance,
8 the label has to be correct, right drug, right
9 quantity, right directions have to be on it
10 before it is dispensed to the patient.

11 Q. And what does DUR stand for?

12 A. Drug Utilization Review.

13 Q. If we turn back to Exhibit 14,
14 this one is easier, it's about the -- there it
15 is (indicating).

16 A. Sorry.

17 Q. Nope. Was that 14? It's the one
18 I just --

19 A. 16.

20 Q. I'm sorry, 16.

21 MS. BROWNE: Is that right, that
22 was 16?

23 MR. WAKLEY: 15.

24 MS. BROWNE: No, it wasn't. It
25 should have been --

1 MR. WAKLEY: The '09 -- or the '08
2 minutes?

3 MS. BROWNE: The '08 minutes.

4 MR. WAKLEY: Those are 15 by my
5 count.

6 THE WITNESS: I have it as 16 on
7 mine.

8 MR. RUIZ: It's 15.

9 MS. BROWNE: Just so the record is
10 clear, the minutes of the December --

11 Is that what you have as the next
12 -- Christy, as the next exhibit? Do you have
13 that? I think it is 15.

14 So the minutes of the December 8th
15 to 9th, 2008 Board of Pharmacy meeting bearing
16 OhioPharmMins_0016 is Exhibit 15 and we were
17 talking about that when we were talking about
18 the code provision 4729-9-16 that pertains to
19 wholesalers.

20 BY MS. BROWNE:

21 Q. If you look back at that Exhibit
22 15 on the third page, the top of the page is
23 4729-5-10, prescription pick-up station.

24 A. Okay.

25 Q. Are you with me?

1 A. Yes, ma'am.

2 Q. No pharmacist shall accept
3 prescriptions obtained from a place which
4 offers in any manner its services as a pick-up
5 station or intermediary for the purpose of
6 having prescriptions filled unless such place
7 is a pharmacy.

8 What is a pick-up station? What
9 is that?

10 A. Why is this a rule?

11 Q. Yeah.

12 A. Okay. I believe that this rule
13 has since been changed, but in some incidences
14 when a doctor is going to prescribe a
15 medication for an injection there was rules
16 that the prescription had to go straight to the
17 patient. In some incidences they wanted to be
18 able to have the prescription, instead of going
19 to a patient's residence where then the patient
20 would carry it into a procedure and it wouldn't
21 be stored properly and everything like that, an
22 ability for a compounded medication or a
23 prescription to be sent to a facility, such as
24 a doctor's office, and it could be held for
25 that patient.

1 Does that make sense?

2 Q. It does.

3 A. Okay.

4 Q. So I was just -- I was trying to
5 figure out what this was meant to address, but
6 this isn't necessarily an opioid-related thing;
7 this is --

8 A. No, this is white bagging, brown
9 bagging.

10 Q. In general, how are rules -- how
11 are the Board of Pharmacy rules enforced? I
12 mean, for example, this pick-up station rule,
13 how would that have been enforced?

14 A. During an inspection it could have
15 been noticed that, hey, there's patient-specific
16 drugs here at this location, where is your
17 pick-up -- you know, are you complying with the
18 pick-up station rule.

19 Q. And the prior page, 4729-3-02,
20 registration as a pharmacy intern, how is that
21 enforced, this rule?

22 A. 02, the registration?

23 Q. Yes, sir.

24 A. So if you're in pharmacy school
25 they require you to do intern hours, and before

1 you can work into a pharmacy you would have to
2 be registered as a registered pharmacy intern
3 with us and it's a licensure process.

4 Q. I know that you mentioned that the
5 wholesaler rule is one of the rules that's
6 changing as of April 15th of this year and you
7 also said the pick-up station rule that we've
8 just looked at that was in effect as of January
9 1st, 2009 is no longer in the same form?

10 A. Yeah, there's been changes to it.

11 Q. Are there other rules directed
12 toward pharmacists specifically that are going
13 to be changed as of April 15th, 2019?

14 A. I'm not sure of the exact rule
15 effective dates that are going into effect, but
16 I'm sure there are.

17 Q. So the rule as to the wholesalers,
18 that's just -- that's one rule that's being
19 effective as of April 15th, but it's not that
20 there is a wholesale rule change going into
21 effect on April 15th, 2019?

22 A. I don't understand your question.

23 Q. Is there more than one rule that's
24 being changed as of April 15th, 2019?

25 A. I don't know what other rules are

1 going into effect on that day. There could be
2 other ones. We're continually updating our
3 rules on a regular basis.

4 Q. Okay. But you do know that the
5 provision as to the wholesalers is being
6 changed?

7 A. Yes, ma'am.

8 Q. And we've looked at some changes
9 in Exhibit 14 about rule updates, correct?

10 A. Yes, ma'am.

11 Q. Other than the rule updates that
12 we looked at from 2017, and I know we didn't go
13 through all of them, but what's set forth as of
14 January 1st, 2009 in Exhibit 15, have there
15 been other updates to rules or regulations that
16 cover pharmacists?

17 A. Yes, ma'am.

18 Q. When?

19 A. I couldn't -- again, we are tasked
20 to review all of our rules over a certain time
21 period. Again, there's been consistent change
22 of our rules over the last several -- since
23 I've been at the board.

24 Q. There isn't a given period when
25 rule making changes are made; for example, we

1 review rules annually and so annually a rule is
2 changed?

3 A. Sometimes there is more activity,
4 but some of them are also legislatively
5 dictated, it's not just rules. Some of it is
6 legislatively dictated where changes are
7 requested to be made, or there's different
8 legislative changes that dictate us to
9 promulgate rules for a certain thing or change
10 rules for a certain thing.

11 So it's not just they're changed
12 on an annual basis or anything like that.
13 Sometimes there's other extenuating
14 circumstances.

15 Q. Can you give me an example of a
16 legislatively dictated rule change?

17 A. House Bill 93 2011 dictated that
18 we license PMCs and we set -- promulgate rules
19 for that also.

20 Q. Other than the rule and regulation
21 promulgation that is done with the board
22 itself, I think you answered this, but does the
23 board ever assist the medical or the dental or
24 the nursing boards with the promulgation of
25 their rules?

1 A. They may have some consultation.
2 We try not to make sure that they conflict
3 (sic). We also have external stakeholders that
4 assist in the rulemaking process.

5 MS. BROWNE: Want to take a break?

6 THE VIDEOGRAPHER: We're off the
7 record.

8 (Recess taken.)

9 THE VIDEOGRAPHER: We're on the
10 record.

11 BY MS. BROWNE:

12 Q. Welcome back, Mr. Griffin.

13 A. Thank you.

14 (Thereupon, Defendants' Exhibit
15 Number 16, Ohio State Board of Pharmacy
16 Newsletter Dated November 2014, was marked for
17 purposes of identification.)

18 BY MS. BROWNE:

19 Q. I'm showing you what has been
20 marked as Exhibit 16. This is November 2014
21 Ohio State Board of Pharmacy Newsletter. I
22 pulled this off your website.

23 Have you seen this document
24 before?

25 A. I have seen the newsletters. I

1 can't recall if I've seen this specific one.

2 Q. Who is the audience of these
3 newsletters?

4 A. The licensees.

5 Q. How often are they issued?

6 A. I believe they're monthly.

7 Q. Who is responsible for issuing
8 them?

9 A. We use a service through NABP;
10 however, Mr. McNamee creates some content with
11 the executive director's input.

12 Q. And NABP is the National
13 Association of Boards of Pharmacy, correct?

14 A. Yes, ma'am.

15 Q. If you turn to the second page --
16 second to third page of the newsletter, the
17 newsletter bears the seals of the CPSC, the
18 FDA, the DEA and the NABP. Do you see that?

19 A. Yes.

20 Q. Is the newsletter cleared with
21 these agencies before it's issued?

22 A. I don't believe it's cleared with
23 them. I think -- I don't know how it works
24 exactly. I know that we submit them
25 information that we would like included and

1 then it is sent out from there.

2 Q. When you say them and it is sent
3 out from there, are you talking about the NABP?

4 A. Yeah, NABP has a service for the
5 Boards of Pharmacies.

6 Q. What role, if any, does the
7 Consumer Product Safety Commission have in the
8 issuance of the Board of Pharmacy newsletter?

9 A. I don't know.

10 Q. What about the FDA, what role do
11 they have?

12 A. I don't know, other than the NABP
13 is putting updated information from those
14 organizations in the newsletter.

15 Q. What would you -- what is the
16 purpose of these newsletters?

17 A. Information, education.

18 Q. If you look back at page 1 of this
19 document in the second column, the second full
20 paragraph starts, another new law enacted by
21 the General Assembly, HB 341, requires a
22 prescriber prior to issuing a prescription for
23 an opioid analgesic or benzodiazapine to query
24 the OARRS database. It also requires all
25 pharmacists to register with OARRS by September

1 15th, 2015.

2 Did I read that correctly?

3 A. Yes, ma'am.

4 Q. It goes on to note the
5 circumstances under which a check of OARRS is
6 required. Do you see that?

7 A. Yes, ma'am.

8 Q. There are five of them, receiving
9 reported drugs from multiple prescribers,
10 receiving reported drugs for more than twelve
11 consecutive weeks, abusing or misusing reported
12 drugs, requesting the dispensing of reported
13 drugs from a prescription issued by a
14 prescriber with whom the pharmacist is
15 unfamiliar, presenting a prescription for
16 reported drugs when the patient resides outside
17 the usual pharmacy geographic population.

18 Did I read that correctly?

19 A. Yes, ma'am.

20 Q. And are those all instances or
21 examples of diversion?

22 MS. RANJAN: Object to form.

23 THE WITNESS: Do what?

24 BY MS. BROWNE:

25 Q. You can answer. She's objecting

1 for the record.

2 A. I wouldn't say that these are all
3 instances of diversion; however, these would be
4 requirements on the prescriber to -- I think
5 they're red flags for the prescriber; however,
6 receiving reported drugs from multiple
7 prescribers could be diversion, abusing or
8 misusing obviously could be diversion. Again,
9 these are more red flags than they are examples
10 of diversion.

11 Q. And this goes on to note that, in
12 conclusion, it's the pharmacist and not the
13 employer or supervisor or fellow employee who
14 is held accountable for making an independent
15 judgment to ensure that a prescription
16 presented at the pharmacy is legitimate?

17 A. Correct.

18 Q. And the reason that this is
19 directed towards physicians and individual
20 pharmacists is that those individuals are the
21 ones who could immediately see if a patient is
22 doctor shopping, right?

23 A. They could, but it also is
24 directed at them because they are the first
25 line and OARRS is a clinical tool where they

1 could see some of these different types of red
2 flags.

3 Q. Well, nobody else can see OARRS
4 except for a doctor, a pharmacist -- or have
5 access to OARRS except a doctor or pharmacist
6 or the board, correct?

7 A. That's incorrect. Their delegates
8 can have access, so a physician can have a
9 delegate run an OARRS report, a pharmacist can
10 now have a delegate that can run an OARRS
11 report for them.

12 Q. But the delegate is inside the
13 pharmacy, right?

14 A. Correct, yes.

15 Q. It's not a corporate
16 representative?

17 A. Correct.

18 Q. So in addition to this -- I'm
19 sorry, the legislation, the report or the
20 newsletter also provides information about
21 changes in DEA or changes from DEA, correct;
22 for example, on page 2, DEA reschedules
23 hydrocodone combination products as Schedule
24 II?

25 A. Yes, ma'am.

1 Q. And then it also includes
2 information about changes that are coming out
3 of FDA, correct; for example, on page 3, FDA
4 lowers recommended starting dose for Lunesta
5 due to risk of morning impairment?

6 A. Yes, ma'am.

7 Q. Back to page 1, the sub (1) reads
8 receiving reported drugs from multiple
9 prescribers. The board is the only entity that
10 can see whether an individual is receiving
11 reported drugs from multiple prescribers,
12 right?

13 A. Well, a pharmacist and a patient
14 profile could see that without utilizing OARRS.

15 Q. Without utilizing OARRS, how?

16 A. Because if you go there as a
17 patient and you go to a dentist one week and
18 you go to your general practitioner one week
19 and they give you two prescriptions, it's going
20 to be on file with the pharmacy.

21 Q. What if you don't go to the same
22 pharmacy?

23 A. Well, then it would not be, but a
24 pharmacist receiving twelve weeks, if you are a
25 regular patient, you may have varying

1 prescribers.

2 Q. Sure, but I was talking about
3 number (1), receiving reported drugs from
4 multiple prescribers.

5 A. Uh-huh, the pharmacist.

6 Q. So if I have multiple -- just bear
7 with me for one second.

8 A. Okay.

9 Q. If I have three prescriptions for
10 hydrocodone, I got one from an orthopedic
11 surgeon, one from a neurologist and one from my
12 primary care, and I went to three different
13 pharmacies to get them filled --

14 A. Right.

15 Q. -- the board is going to know
16 that, but the pharmacy -- the pharmacist at
17 pharmacy A, pharmacy B and pharmacy C won't
18 know that I've gone to three different
19 pharmacies with the same prescription, will
20 they?

21 A. In that scenario that would be
22 correct, unless they are all with the same
23 chain.

24 Q. Well, I'm smarter than that.

25 A. Okay.

1 Q. So if I'm going to Joe's pharmacy
2 with one hydrocodone prescription, Ed's
3 pharmacy with the second prescription and Mary
4 Jane's pharmacy with prescription three,
5 they're all independent pharmacies, the only
6 entity that knows that I've got three
7 prescriptions for hydrocodone at the exact same
8 time is the board, right?

9 A. Yes. However, I would also say
10 the insurance provider, if insurance was
11 utilized.

12 Q. Is there any way to -- looking
13 back, I'm sorry, at Exhibit 16, is there any
14 way for the board to monitor compliance with
15 that regulation other than by using OARRS?

16 A. Compliance with this regulation?

17 Q. Yeah, with 4729-5-20.

18 A. I wouldn't see how.

19 Q. If the board determines that a
20 pharmacist has failed to abide by this code
21 provision --

22 Well, let me ask you this: How is
23 it determined that a pharmacist has failed to
24 abide by this code provision?

25 A. We would have to do an

1 investigation and review the OARRS request
2 verse the dispensing request and then go to the
3 pharmacy and look at the original records, such
4 as the prescription, dispensing logs, patient
5 profiles.

6 Q. But in the first instance how
7 would you know? How would you know that a
8 violation occurred?

9 A. We wouldn't. A violation of
10 4729-5-20, we wouldn't know a violation
11 occurred other than potentially a patient that
12 is getting a new prescription wasn't ran at
13 all, but to -- the issue is that the OARRS
14 requests are done specifically by the
15 pharmacist, the dispensing is specifically to
16 the pharmacy.

17 Q. So, for example, if a pharmacist
18 is filling or dispensing prescriptions from
19 multiple prescribers for the same opioid to one
20 customer/patient, is a report automatically
21 generated to flag that for the board?

22 A. There's no way for us to know.
23 OARRS doesn't -- again, they're not linked.

24 Q. So if a customer is going to the
25 pharmacy and receiving multiple prescriptions

1 from multiple prescribers for an opioid
2 medication, the only way the board would become
3 aware of that is if somebody happened to look
4 at it in OARRS or it received a complaint?

5 A. So I think you're asking two
6 separate questions.

7 Q. Okay.

8 A. Your first one was specific to a
9 pharmacist, where OARRS is not linked to the
10 pharmacist. It is linked -- OARRS dispensing
11 is not linked to the specific pharmacist.
12 OARRS checks our link to the specific
13 pharmacist, but not the specific pharmacy.

14 Q. But it's the pharmacist with -- or
15 his or her delegate who has the --

16 A. Right. So the second question is
17 if they come to -- if they come to the pharmacy
18 and they're receiving multiple prescriptions
19 from different doctors, the pharmacist would
20 have to check OARRS. If you go with the same
21 scenario where they're all independent
22 pharmacies, how would the pharmacist know, they
23 would have to check OARRS.

24 Q. I'm not talking about the
25 pharmacist, I'm talking about the board. You

1 guys could see it.

2 A. Okay. So how would we see it,
3 yes.

4 Q. So you would see it if you just
5 happened to be -- so that's what I'm asking, is
6 there an automatic flag?

7 A. Absolutely. That was the doctor
8 shopper report --

9 Q. Okay.

10 A. -- that comes up on a monthly
11 basis.

12 Q. All right.

13 A. And with doctor shoppers we've
14 dramatically reduced the numbers from the
15 thousands to a couple hundred.

16 Q. We talked about the board
17 conducting hearings and reaching settlement
18 agreements, but after -- if the board conducts
19 a hearing and decides or determines to suspend
20 or revoke a license, is there an appeal
21 process?

22 A. There is.

23 Q. What is it?

24 A. It would have to go to the county
25 court.

1 Q. And who participates in appeals?

2 A. I'm assuming the respondent, their
3 attorney, our Attorney General that represents
4 the board.

5 Q. Is the appeal -- the issuance of a
6 suspension or a revocation of a license is
7 public, correct?

8 A. Yes, ma'am.

9 Q. Is the appeal public?

10 A. I would assume so.

11 Q. What is a pink sheet?

12 A. Well, a pink sheet is a term from
13 when we used to do handwritten inspection forms
14 and I believe it was -- sheet number three was
15 actually pink in color and that was the one
16 that was left with the terminal distributor.
17 And if you received a pink sheet, that also
18 indicated that you had to provide a written
19 response or a corrective response to
20 deficiencies that were found in the pharmacy.

21 Q. And does the board still issue
22 pink sheets?

23 A. They have been renamed, due to
24 technology, to written warnings.

25 Q. So the board does still issue

1 written warnings, but they don't refer to them
2 as pink sheets?

3 A. Yeah, we don't refer to them as
4 pink sheets. We went -- in 2015 we developed a
5 digital web-based system for inspections, and
6 so hence the name change from a pink sheet to a
7 written warning.

8 Q. Failure to report required
9 prescription data to OARRS is an offense that
10 would warrant a written warning?

11 A. It depends under what
12 circumstances. If it was an ongoing, it would
13 -- it would probably get -- or any failure to
14 report would get a written warning; however,
15 some of those would also get escalated up to a
16 citation review committee.

17 Q. And how do you monitor for a
18 failure to report a required -- failure to
19 report prescription data to OARRS? How do you
20 know that?

21 A. That would be an OARRS question.
22 I don't know.

23 Q. Do you know what a dangerous drug
24 inspection report is?

25 A. Yes, ma'am.

1 Q. What is it?

2 A. That's our inspection report that
3 I've been referring to through the course of my
4 testimony.

5 Q. We talked about the public
6 complaint earlier and that some of -- you've
7 even received complaints about my co-pay went
8 up, all sorts of things. Have you received
9 complaints about specific hospitals or clinics
10 through that public complaint process?

11 A. I'm sure we have.

12 Q. Have you received complaints about
13 out-of-state facilities through that public
14 complaint forum?

15 A. Yes, ma'am.

16 Q. You've mentioned the National
17 Association of Boards of Pharmacy a couple
18 times today, one in which we talked about them
19 being part of the issuance of Exhibit 16, the
20 Board of Pharmacy newsletter. And I think you
21 mentioned that you're also -- you, through the
22 board, participate on a task force with NABP;
23 is that correct?

24 A. It was a working group for the
25 national sterile compounding inspection

1 blueprint.

2 Q. What is that?

3 A. It was efforts by all the states
4 in NABP to standardize compounding inspections
5 of facilities in all the -- across the United
6 States; that way you had some comfort in
7 licensing out-of-state compounders.

8 Q. Other than the work on the
9 newsletter and this compounding inspection
10 blueprint, have there been other times when the
11 board has collaborated with the NABP?

12 A. I think we've collaborated with
13 NABP on a multiple of things. I think we have
14 ongoing conversations with NABP, whether it's
15 model practice; however, formally being on a
16 committee or a task force or a work group, the
17 only other one that comes to mind is our
18 executive director was asked to chair a work
19 group on suspicious orders where other states'
20 representatives were among those.

21 They had also met with industry,
22 including the HDA, Healthcare Distribution
23 Alliance, in consultation, and made
24 recommendations to changes to the Model
25 Practice Act that NABP offers or utilizes.

1 Q. Do you know what changes to the
2 Model Practice Act were made?

3 A. I don't know all of them. I know
4 some of the highlights, again, were reporting
5 customers that were cut off, doing additional
6 due diligence on the customers of the
7 wholesalers and providing information in a
8 standard format. I know I'm missing a couple
9 other ones. Oh, and timely reporting.

10 Q. Does the board have any role in
11 the enforcement of the Ohio Controlled
12 Substances Act?

13 A. Yes, ma'am.

14 Q. What is that?

15 A. It's the same as our investigative
16 authority, investigating complaints involving
17 controlled substance, whether that's a theft,
18 whether it's illegal processing.

19 MS. BROWNE: I may be done. I
20 need to review my notes. I don't know if any
21 of my colleagues have questions that they want
22 to ask while I take a look.

23 MR. MORIARTY: I have some.

24 MS. BROWNE: All right. Want to
25 trade places here, Matt, or do you want me to

1 try to throw you down a microphone?

2 MR. MORIARTY: Well, there's a
3 microphone here. Is this for me or is this for
4 the telephone?

5 THE VIDEOGRAPHER: Yes, sir. Go
6 ahead.

7 * * *

8 CROSS-EXAMINATION

9 BY MR. MORIARTY:

10 Q. Ready?

11 A. Yes, sir.

12 Q. The disadvantage of going second
13 is that your notes are all over the place,
14 okay.

15 So let me ask you, there have been
16 some meeting minutes already marked as
17 exhibits, and in order to try and avoid marking
18 more, let me just ask you a couple of general
19 questions. At these board meetings are you
20 there at most of them, where these minutes are
21 kept and where they come from?

22 A. No. I will make an appearance at
23 the board meeting to give a report --

24 Q. Okay.

25 A. -- but I am not there for the

1 entire board meeting.

2 Q. Do you ever look at the minutes?

3 A. Occasionally.

4 Q. Are you aware that there, from
5 time to time, are people who make what are
6 called the legislative report to the board?

7 A. I am aware of that.

8 Q. And do you know if that has been
9 true for many years, going back into, say, the
10 1990s?

11 A. I don't know that.

12 Q. And the legislative report, I
13 assume, is somebody talking about what the Ohio
14 legislature may be considering talking about or
15 that they may, in fact, be voting upon in the
16 near future, correct?

17 A. I believe so.

18 Q. And then also the board in these
19 minutes, as Ms. Browne quizzed you about, has a
20 role in rulemaking; in other words, writing
21 parts of the Ohio Administrative Code?

22 A. Yes, sir.

23 Q. Has that been true for many years,
24 that the board has rulemaking or rule writing
25 authority?

1 A. Ever since I've been employed at
2 the board, I believe so.

3 Q. Do you know if that practice was
4 in place back in the '90s?

5 A. I don't know. I would assume so.

6 Q. So if Ohio legislature in the
7 1990s passed some piece of legislation that
8 directly or indirectly impacted on the universe
9 that you at the board supervise, the board
10 could have some rule writing role --

11 A. Yes, sir.

12 Q. -- that goes into the Ohio
13 Administrative Code?

14 A. Yes, sir.

15 Q. I see from time to time in these
16 minutes that there are discussions of Mrs. Droz
17 presenting the Ohio Automated Prescription
18 Reporting System update?

19 A. Yes, sir.

20 Q. Is that somebody talking about
21 what's going on with OARRS?

22 A. Yes, she was the OARRS
23 administrator prior to Mr. Garner.

24 Q. And from time to time I see in the
25 minutes that there are references to a

1 particular provider of continuing education
2 applying to be -- I don't know whether you call
3 it a certified provider or a preferred
4 provider. Have you seen that in the past?

5 A. Yes. I don't know if they're
6 certified or preferred either. I think it's
7 just being recognized as a provider of CE.

8 Q. But they have to apply, they're
9 not just -- they don't just automatically get
10 to set up shop and have pharmacists or other
11 licensees get the credit from them?

12 A. Yes, sir.

13 Q. You want to make sure that they
14 have some quality to them, correct?

15 A. Correct.

16 Q. Now, you have been asked about
17 some newsletters, and unfortunately a couple of
18 those I do want to mark.

19 MR. MORIARTY: Can I have some
20 exhibit stickers?

21 MS. BROWNE: That's 17.

22 BY MR. MORIARTY:

23 Q. Would you agree with me that, so I
24 don't have to mark all of these, the newsletter
25 to some degree is involved in addressing the

1 licensees and their continuing education
2 requirements, true?

3 A. I believe so.

4 Q. And the newsletters also discuss
5 as they do at the meetings and in their
6 minutes, changes in rules and updates from the
7 Ohio legislature?

8 A. Yes, sir.

9 (Thereupon, Defendants' Exhibit
10 Number 17, Ohio State Board of Pharmacy
11 Newsletter Dated May 2010, was marked for
12 purposes of identification.)

13 BY MR. MORIARTY:

14 Q. Let me hand you what I've had
15 marked as Exhibit 17. I'll put this up in the
16 right-hand corner because there's more room.

17 MR. MORIARTY: One for the
18 witness, one for you, a couple more. I don't
19 think I have enough for everybody.

20 BY MR. MORIARTY:

21 Q. Is that an Ohio State Board of
22 Pharmacy newsletter from May of 2010?

23 A. Yes, sir.

24 Q. And you were working there at the
25 time?

1 A. Yes, sir.

2 Q. In your role in enforcement did
3 you have anything to do with the drafting of
4 these newsletters?

5 A. No, sir.

6 Q. And tell me again, I think I
7 missed it, is it the national association that
8 has the primary role in drafting these?

9 A. Yes. The board of -- or the NABP,
10 the National Board of Pharmacy Association,
11 assists with drafting these.

12 Q. And who would -- who from the Ohio
13 board would be providing the national
14 association with the Ohio-specific data?

15 A. I believe that would be the
16 director of communication or legislative
17 affairs or the executive director.

18 Q. All right. Now, if you go to the
19 last page of this, there's a section called
20 corresponding responsibility is needed more
21 than ever. Do you see that?

22 A. Yes, sir.

23 Q. And corresponding responsibility
24 has to do with the fact that there are several
25 different people or entities involved in making

1 sure the prescriptions are handled properly,
2 correct?

3 A. Yes, sir.

4 Q. And this indicates, as many of you
5 know, we are having a tremendous problem in
6 Ohio with so-called pain clinics who are doing
7 nothing but providing large amounts of
8 controlled substances, particularly oxycodone
9 and hydrocodone, to people who have no
10 legitimate medical need for them. Do you see
11 that?

12 A. Yes, sir.

13 Q. And then it goes down to talk
14 about in several areas of Ohio the abuse and
15 misuse of these drugs has reached epidemic
16 proportions, and then it goes on.

17 Did I read that correctly, by the
18 way?

19 A. Hold on. I'm looking for where
20 you were.

21 Q. I just went down maybe four lines
22 from the first part I read. In several areas
23 of Ohio.

24 A. Yes. Okay. Yes, sir.

25 Q. I read that correctly?

1 A. Yes, sir.

2 Q. So even back in 2010 they were
3 referring this to -- to this as an epidemic?

4 A. Yes, sir.

5 Q. And were they referring -- they,
6 or you in your job there from 2008 to 2010,
7 referring to it as an epidemic?

8 A. I'm sure I was.

9 Q. Before 2008 in your role -- in
10 your various other roles, were you referring to
11 it as an epidemic, even from what you knew as a
12 sheriff's deputy?

13 A. I would not have known the level
14 of detail of abuse of prescription drugs. I
15 would not say that I would at that point in
16 time have the knowledge that I did once I
17 joined the board.

18 Q. You saw it locally in Delaware
19 County, and then when you got to the board you
20 realized this is going on all over the place?

21 A. Correct.

22 Q. And this is the point at which
23 Governor Strickland was issuing an executive
24 order creating the drug task force, correct?

25 A. According to this, yes, sir.

1 Q. All right. You can put that one
2 aside, and let me just mark this one as Exhibit
3 18.

4 (Thereupon, Defendants' Exhibit
5 Number 18, Ohio State Board of Pharmacy
6 Newsletter Dated May 2011, was marked for
7 purposes of identification.)

8 BY MR. MORIARTY:

9 Q. This is the following year in May.
10 Do you have that Number 18 in front of you?

11 A. Yes, sir.

12 Q. On the first page of this one,
13 does it say corresponding responsibility is
14 needed more than ever?

15 A. Yes, sir.

16 Q. Then it refers to last May's
17 newsletter, the one I just marked as Exhibit
18 17, correct?

19 A. Yes.

20 Q. And then it goes through a
21 discussion very similar to what was in the May
22 2000 -- I'm sorry, the 2010 version, correct?
23 If you follow the article --

24 A. Yeah, I've got to switch to page
25 4.

1 Q. Right?

2 A. Yes, sir.

3 Q. Okay. And it's talking about the
4 board has had calls from pharmacies as far away
5 as Virginia and South Carolina asking about the
6 legitimacy of prescriptions, right?

7 A. Yes, sir.

8 Q. And then House Bill 93 was sort of
9 imminent at that point, correct?

10 A. Yes.

11 Q. That's all I want to ask you about
12 that one.

13 Now, as I understand it,
14 compounding pharmacies have traditionally in
15 the United States been inspected and regulated
16 by state boards of pharmacy; is that true?

17 A. Yes, for the most part.

18 Q. But manufacturers of
19 pharmaceuticals are traditionally regulated by
20 the FDA, correct?

21 A. Correct.

22 Q. Have you as a member of the Board
23 of -- or an employee of the Board of Pharmacy
24 ever had communication directly with
25 pharmaceutical manufacturers?

1 A. If I had communication with a
2 manufacturer, it would have been -- I don't
3 recall any of the big manufacturers. It would
4 probably be a virtual manufacturer or a smaller
5 manufacturer.

6 Q. Okay. Have you ever sought to
7 investigate what you consider one of the big
8 manufacturers?

9 A. Not to my knowledge.

10 Q. Let me just flip through my notes.

11 A. No problem.

12 Q. I don't have that much more.

13 When you said that you were one of
14 the drug task force commanders --

15 A. Yes, sir.

16 Q. -- plural --

17 A. No, no, just one.

18 Q. Okay.

19 A. There's only one.

20 Q. Were you collaborating with the
21 task force commanders in other counties?

22 A. Oh, yes, on a regular basis. I
23 apologize. There's an association for the Ohio
24 Task Force -- Drug Task Force Commanders
25 Association, so all of the drug task forces

1 across the state, their commanders had an
2 association and we collaborated together.

3 Q. So remind me in what years you
4 were involved in that. Was that 2000, 2002,
5 back that far?

6 A. It would have been 2002 -- 2002,
7 2003 to 2005, 6. And then I still oversaw the
8 drug task force even as a lieutenant; however,
9 there was an operations commander in charge.

10 Q. How many of our 88 counties back
11 then had drug task forces with which you
12 collaborated?

13 A. It varied between, I think, the
14 numbers of 24 and 28 --

15 Q. Were -- go ahead.

16 A. -- that were sort of local task
17 forces that operated across the state. That
18 doesn't include some of the federal task forces
19 that went on.

20 Q. Was Cuyahoga County one with which
21 you collaborated?

22 A. I think they had a couple
23 different task forces within Cuyahoga County.
24 The Caribbean/Gang Task Force was based out of
25 Cuyahoga County and also the Seal Drug Task

1 Force was based out of Cuyahoga County. Those
2 are the two that I can remember off the top of
3 my head.

4 Q. That you collaborated with?

5 A. Yes.

6 Q. Did Summit County have a task
7 force that you collaborated with?

8 A. They did.

9 Q. You and Ms. Browne were talking
10 about these reports that have been run in the
11 last few years that compared overdose deaths
12 with OARRS reports.

13 A. Yes, sir.

14 Q. I have a couple of questions about
15 that.

16 A. Okay.

17 Q. When she asked you, you didn't
18 know if those reports had ever been made
19 public. Have you checked into that or thought
20 more about it since she asked you about that
21 hours ago?

22 A. I have not checked into it or
23 thought any more about it.

24 Q. Do you know anything about the
25 methodology by which those statistics were run

1 or compared?

2 A. I do not know.

3 Q. You were just given raw data,
4 that's it, or the end product?

5 A. Yes, sir.

6 Q. Who at the Board of Pharmacy would
7 know the most about how those reports were run,
8 compiled and analyzed?

9 A. Chad Garner.

10 Q. Ms. Browne asked you about Exhibit
11 5, which is this news article about the
12 pressure from the Governor's office for a
13 director of the Board of Pharmacy to resign.
14 Do you remember that?

15 A. Yes, sir.

16 Q. Okay. Are you aware of any
17 correspondence from the Governor's office which
18 indicated that their office was unhappy with
19 either the board, the employees of the board,
20 or the executive director?

21 A. Am I aware of any correspondence?

22 Q. Yes. For example, did you
23 personally see a memo or a letter or a
24 directive indicating that the Governor's office
25 was unhappy with the board or someone in the

1 board's office?

2 A. I never directly saw a memo or any
3 type of correspondence or directives.

4 Q. Well, did you ever see one
5 indirectly?

6 A. Or indirectly, no, I did not. I
7 did not see any correspondence.

8 Q. Was that ever discussed as a
9 meeting -- at a meeting?

10 A. Not specific correspondence;
11 however, we had got the information from the
12 executive director at the time, which would
13 have been Kyle Parker.

14 Q. Okay. So the gentleman who was
15 being pressured is the one who gave you the
16 information?

17 A. Correct.

18 Q. Okay. What current employee at
19 the Board of Pharmacy would know the most about
20 that incident?

21 A. I don't know if we have one.

22 Q. Okay. Let me ask it a different
23 way. I think the allegation in the article,
24 without reading it again, was that the director
25 was sitting on his hands regarding the opioid

1 crisis.

2 What current employee would know
3 the most about whether the then-director was or
4 was not sitting on his hands in some way
5 regarding the opioid crisis?

6 A. I think I could answer that.

7 Q. Okay. So was the then-director
8 sitting on his hands in some way?

9 A. I didn't feel like he was. I
10 think we were utilizing all of our resources
11 for a small agency to do as much as we possibly
12 can. I think that -- I don't know if at his
13 level there was the same type of cooperation
14 between the different regulatory boards. And
15 we definitely had a change in -- some change in
16 directives after Kyle left; however, I don't
17 know that he was sitting on his hands. We
18 weren't ordered not to investigate anything or
19 not to do anything like that. I just think the
20 Governor's office wanted things done faster.

21 Q. Okay. Now, you referred to some
22 external stakeholders who helped in the
23 rulemaking process.

24 A. Yes, sir.

25 Q. Name some categories of people or

1 entities who would be external stakeholders in
2 that process.

3 A. Sure. So they have a rules review
4 committee that pharmacists and associations can
5 apply, so they do sort of a pre-draft of the
6 rules. They preview it to the committee; for
7 an example, hospital pharmacist, if it's going
8 to affect institutional pharmacy they're going
9 to want to get experts from the institutional
10 world, associations, Ohio Pharmacist
11 Association, OSHP, the Ohio Hospital Pharmacist
12 Association. I think there's an American
13 Pharmacist -- Hospital Pharmacy Association,
14 the HDA, the Healthcare Distributor
15 Association. There's several, several --

16 Q. Okay.

17 A. And they provide feedback and we
18 make changes to those feedbacks. We have open
19 discussions about it. Sometimes they'll put it
20 in writing, sometimes it's just verbal in a
21 meeting.

22 Q. Okay. And you're not getting
23 feedback from pharmaceutical manufacturers?

24 A. I don't -- I couldn't tell you if
25 there was or wasn't anybody from pharmaceutical

1 manufacturers in any of those meetings.

2 Q. Now, I thought I understood OARRS
3 and then I got confused when you two were
4 talking about going to Jane's pharmacy and all
5 those, so let me ask you a pretty simple
6 question.

7 In Mrs. Browne's example where one
8 person goes to three different pharmacies to
9 fill a prescription of a scheduled drug, OARRS
10 would detect that if the pharmacist or the
11 doctor checked OARRS, correct?

12 A. They could.

13 Q. Okay.

14 A. You're asking if OARRS can
15 determine that a pharmacist or a physician
16 checked OARRS?

17 Q. No. They would -- a pharmacist or
18 physician checking OARRS would know that the
19 patient in front of them had been to several
20 different pharmacies to get prescriptions
21 filled?

22 A. Yes, sir.

23 Q. Okay. So the three people who
24 would know that if they check OARRS are the
25 board, the pharmacist, and the doctor?

1 A. Correct.

2 Q. And even if it happened in
3 relatively short period of time, that data
4 should be entered and available promptly,
5 correct?

6 A. Yes, we -- I can't remember the
7 year that we went to daily reporting, but it
8 wasn't -- OARRS wasn't always a daily reporting
9 program. I can't remember the time period
10 prior to it, but sometimes there was a delay
11 early on when OARRS first --

12 Q. Got it. And you said that the
13 doctor shoppers report had reduced the number
14 from the thousands to the hundreds.

15 A. Yes, sir.

16 Q. The number of doctor shoppers?

17 A. On the list. However, the list is
18 only as good as the data entry, so you have to
19 verify all of that information, and sometimes
20 there are errors in it because a human is
21 typing that information in.

22 Q. Sure.

23 A. So sometimes what comes on the
24 doctor shopper list may be wrong.

25 Q. And some new ones can come on?

1 A. Oh, absolutely.

2 Q. Okay. But when you said the
3 number, you were talking about the number of
4 human beings who were being categorized as
5 doctor shoppers?

6 A. Yes, sir.

7 Q. You talked about over-utilization
8 and over-prescribing. If the board finds out
9 through some complaint process or its own
10 checking of statistics that there is somebody
11 who is over-prescribing, does the board
12 investigate that?

13 A. Yes.

14 Q. That's the type of thing that the
15 board can investigate?

16 A. Yes, sir.

17 Q. Is over-prescribing itself
18 something that someone can be disciplined for?

19 A. We would investigate it solely as
20 a criminal matter to see if it was not for a
21 legitimate medical purpose and we would
22 investigate it in that manner. If it did not
23 reach that scope or that threshold, we would
24 refer it to the medical board for
25 administrative action, and most likely from the

1 beginning of it the medical board would have
2 been involved.

3 Q. Okay. So when Ms. Browne asked
4 you about this task force report, Exhibit 6 --

5 A. Yes, sir.

6 Q. -- she asked you based on page --
7 the bottom of page 4 about the causes, and you
8 said two things; you said diversion and
9 over-prescribing. That's what you said. Okay?

10 A. Okay.

11 Q. Do you remember that?

12 A. Yes, sir.

13 Q. So diversion is clearly illegal,
14 correct?

15 A. Yes.

16 Q. And over-prescribing, if properly
17 investigated and proven, is also unlawful,
18 correct?

19 A. Yes, it can be illegal.

20 Q. All right. And the report on the
21 next page, 5, doesn't get into
22 over-prescribing; it just talks about three
23 forms of diversion, being doctor shop -- I'm
24 sorry, two forms, doctor shopping and pill
25 mills, correct?

1 A. Yes.

2 Q. Based on what you know and what is
3 in this task force report, it's clear that the
4 epidemic or crisis, whatever term you want to
5 put on it, was multi-factorial, correct?

6 A. Yes.

7 Q. I would assume that neither -- you
8 never assigned any percentage as to what of the
9 many factors contributed to it, correct?

10 A. I did not.

11 Q. Do you think it would be
12 impossible to do that?

13 A. Yeah, yes.

14 Q. Based on what you've told me,
15 diversion would be a large percentage, correct?

16 A. Diversion and over-prescribing.

17 Q. Those would be the majority,
18 correct?

19 A. Yes, sir.

20 MR. MORIARTY: Thanks. That's all
21 I have.

22 MS. MCNAMARA: I just have a
23 couple of questions.

24 * * *

25 CROSS-EXAMINATION

1 BY MS. MCNAMARA:

2 Q. Mr. Griffin, my name is Colleen
3 McNamara. I represent Cardinal Health. I just
4 have a couple of questions for you.

5 (Thereupon, Defendants' Exhibit
6 Number 19, Settlement Agreement with the State
7 Board of Pharmacy in the matter of Cardinal
8 Health 110, Inc., was marked for purposes of
9 identification.)

10 BY MS. MCNAMARA:

11 Q. I'm passing you down the long
12 table what I've marked as Exhibit 19, and this
13 is a document that's Bates labeled BOP_MDL 1st
14 Production_0110318. It's a settlement
15 agreement with the State Board of Pharmacy in
16 the matter of Cardinal Health 110,
17 Incorporated. Do you see that?

18 A. Yes, ma'am.

19 Q. Have you seen this document
20 before?

21 A. Yes.

22 Q. And do you recall earlier in the
23 day you testified that Cardinal Health had been
24 disciplined by the Board of Pharmacy back in
25 2008?

1 A. Yes, ma'am.

2 Q. And is the settlement agreement
3 that I've handed to you the matter that you
4 were referring to earlier today?

5 A. If you don't mind me reading over
6 it.

7 Q. Go for it, and I apologize for the
8 toner issue.

9 A. Yes, ma'am.

10 Q. Thank you.

11 And could you just read into the
12 record the third paragraph up from the bottom
13 beginning with Cardinal Health 110, Inc.
14 neither?

15 A. Neither admits nor denies the
16 allegations pending in the board's
17 investigation; however, the board has initiated
18 and conducted an investigation pursuant to the
19 mandate of Section 3719-18 and 4729-25 of the
20 Ohio Revised Code.

21 MS. MCNAMARA: Thank you. That's
22 all I have.

23 * * *

24 CROSS-EXAMINATION

25 BY MR. EMCH:

1 Q. Doing okay?

2 A. Doing good.

3 Q. The Exhibit 19 that you just
4 looked at --

5 A. Yes, sir.

6 Q. -- I believe you testified before,
7 am I correct, that this represents the only
8 time of which you are aware as you sit here
9 today that any wholesale drug distributor
10 defendant was sanctioned in any way by the
11 board?

12 A. No, we've had others.

13 MS. MCNAMARA: Objection. Form.

14 BY MR. EMCH:

15 Q. Are you aware of all of the
16 defendants in the case?

17 A. All the defendants in this case?

18 Q. Yes, that's my question.

19 A. I know the big ones. I don't know
20 all of them.

21 Q. All right. We went through them a
22 little bit before. AmerisourceBergen Drug
23 Corporation, you've heard of them?

24 A. Yes, sir.

25 Q. Any sanctions against them?

1 A. Not that I can recall.

2 Q. Now I'll just give you the names.

3 We've already talked about Cardinal?

4 A. Yep.

5 Q. And you just say yes or no, okay?

6 A. Okay.

7 Q. McKesson?

8 A. No.

9 Q. Anda?

10 A. I cannot recall Anda.

11 Q. Preservation Supply -- or
12 Prescription Supply, I'm sorry. Prescription
13 Supply - I can't read my own writing - Inc.?

14 A. I do not know.

15 Q. Don't recall any?

16 A. I don't recall.

17 Q. HBC Service Company?

18 A. I don't recall.

19 Q. H.D. Smith?

20 A. Yes, I believe we've had previous
21 discipline with H.D. Smith.

22 Q. Do you remember the number, when,
23 any kind of detail at all?

24 A. I don't.

25 Q. Should that appear in the records

1 that have been produced by the Board of
2 Pharmacy?

3 A. Yeah, I believe we've turned over
4 all of our disciplinary actions.

5 Q. And I'm not sure if we're done
6 with that production or not. I know we didn't
7 get through all of it before today.

8 MR. WAKLEY: Disciplinary actions,
9 yes, you should have the complete record that
10 the board has found.

11 BY MR. EMCH:

12 Q. So if there were any kind of
13 sanction, it would be in the records --

14 A. Yes, sir.

15 Q. -- that we should have?

16 Okay. Questions about pill mills
17 early on, remember?

18 A. Yes, sir.

19 Q. And you described pill mills, and
20 am I correct that what you were describing as
21 pill mills are what we've also talked about
22 from that vintage as pain clinics?

23 A. I think there's legitimate pain
24 clinics and then there's pill mills. That's
25 what they were originally labeled by everybody,

1 I guess; however, I do think there's a
2 distinction between a pain management clinic
3 and a pill mill.

4 Q. But the pill mills of which you
5 are aware were masquerading as pain clinics,
6 would that be a way to say it?

7 A. Initially, yes, sir.

8 Q. And did you become aware of these
9 pill mills during the time you were in law
10 enforcement?

11 A. No.

12 Q. You became aware of them once you
13 came to the Board of Pharmacy?

14 A. Yes, sir.

15 Q. But didn't run into them when you
16 were with the sheriff's department or any of
17 those?

18 A. No, we did some prescription drug
19 cases, but no pill mills.

20 Q. To your knowledge were pain
21 clinics regulated in the State of Ohio prior to
22 the passage of what we call the pill mill
23 legislation in May of 2011?

24 A. The only regulation was from the
25 medical board for the licensed prescriber, so

1 other than that, that was the only regulation
2 that I know of.

3 Q. So as a pain clinic or what we
4 would call legitimate or illegitimate pain
5 clinics, they weren't regulated prior to May of
6 2011?

7 A. The facilities themselves were not
8 licensed.

9 Q. Now, pill mill pain clinics, as we
10 would describe them that existed in, say, 2011
11 when the act was passed, do they still exist?

12 A. Nearly not like they do today and
13 nor -- some drug trends have shown that they've
14 moved away from traditional pain management
15 drugs of oxycodone and hydrocodone to other
16 types of drugs.

17 Q. You're talking about the
18 legitimate pain clinics now?

19 A. No, I believe that there's other
20 pill mills that exist today that -- and I can't
21 get into too much because it's confidential
22 information, but they are not like they were in
23 2011 with lines out the doors and people coming
24 from all over the state and out of state, cash
25 paying doctors. They're not like they used to

1 be.

2 Q. So the legislation has served its
3 function?

4 A. I believe so.

5 Q. Let me ask you to go back to
6 suspicious order reporting, and you've got two
7 exhibits that I want you to look at, Numbers 13
8 and 15.

9 A. Yes, sir.

10 Q. And 15 has the suspicious order
11 regulation in it, and I'm sorry, I don't have
12 the page number, but it's pretty far into it
13 and it's H(1)(e).

14 A. Yes, sir.

15 Q. And 13, Exhibit 13 is an example
16 of a suspicious order report, right?

17 A. Correct.

18 Q. Looking at -- again, at H(1)(e)(1)
19 -- or (i) and (ii), were those already in
20 effect in January of 2009, if you know?

21 A. I believe they were.

22 Q. They had been in effect for a long
23 time --

24 A. Yes, sir.

25 Q. -- right?

1 So they weren't amended or changed
2 in January of 2009, they were already in
3 existence?

4 A. I don't believe so. They were
5 already in effect.

6 Q. And so the board had been
7 receiving suspicious order reports for a long
8 time prior to January of 2009?

9 A. I believe so.

10 Q. Exhibit -- well, let me stick with
11 Exhibit 15 for now. Do you agree that H(1)(e)
12 is a reporting requirement?

13 A. Yes, sir.

14 Q. And H(1)(e)(i) -- well,
15 H(1)(e)(ii) names the things that are to be
16 included in the report. Do you see that, the
17 last sentence?

18 A. Yes.

19 Q. And the example that we have in
20 Exhibit Number 13 does list all of those things
21 that are required to be in the report, doesn't
22 it?

23 A. Yes, sir.

24 Q. And what is required to be in the
25 report, (e)(ii), doesn't include any kind of

1 further explanation or comments about reasoning
2 or things like that?

3 A. No, sir.

4 Q. Now, the board does inspections of
5 wholesale drug distributors --

6 A. Yes, sir.

7 Q. -- also, doesn't it?

8 A. Yes, sir.

9 Q. You'll go to a distribution
10 center?

11 A. One of our staff will, yes.

12 Q. And you look at documents and
13 things when you do that?

14 A. Yes, sir.

15 Q. And one of the documents you may
16 look at is the order monitoring program of the
17 distributor?

18 A. Yes, sir.

19 Q. And you do that?

20 A. That may be one of the things
21 that's checked during an inspection.

22 Q. Now, in your tenure as a
23 compliance officer, do you know of any time
24 when the Board of Pharmacy has criticized or
25 suggested that changes be made or that

1 structures of order monitoring programs of
2 wholesale drug distributors be altered?

3 A. I think our discussions were not
4 around them to be altered, but help -- well, I
5 guess help us provide more context to them,
6 because a thousand pills solely to Ritzman's
7 Pharmacy doesn't mean a whole lot to us. We
8 need more context to why is it suspicious.

9 Q. Okay. Turning to Exhibit 13, my
10 understanding of your testimony was that --
11 what you just said basically, that, you know,
12 numbers alone don't really mean much, you need
13 more information --

14 A. Correct.

15 Q. -- in order to determine if an
16 order is really suspicious?

17 A. Yes, sir.

18 Q. Now, I would like to get a little
19 bit more detail about how suspicious order
20 reports have been handled at the Board of
21 Pharmacy.

22 A. Okay.

23 Q. So let's say -- take the date off
24 of Exhibit 13, and let's say we're sitting in
25 the Board of Pharmacy today and this report

1 comes in, and let's say it's 2008, because I
2 want to understand how this worked over time
3 and whether or not it's changed. And so, you
4 know, 2008 to today, is it different today or,
5 you know, last month or last year than it was
6 in 2008, okay.

7 So we'll kind of start with it
8 comes into the -- well, let me back up. Has it
9 changed? Is it different now than it was back
10 then?

11 A. I believe so.

12 Q. All right. Has it gotten more
13 detailed or --

14 A. Yes.

15 Q. -- receive more attention now than
16 it did?

17 A. I can't recall prior to being
18 promoted to compliance and enforcement
19 supervisor receiving suspicious orders in the
20 field, so --

21 Q. That would have been what date?

22 A. 2008 to 2012. However, once I was
23 promoted and I was working in the office,
24 suspicious orders were handled by an
25 administrative supervisor and were basically at

1 that point in time catalogued in binders by
2 year.

3 Q. All right. So after you came and
4 up until 2012, you did not become aware
5 yourself in your duties of suspicious order
6 reports; they weren't shared with you, you
7 didn't have to look at them, you didn't do
8 anything with them?

9 A. It wasn't part of my regular
10 duties to look at them, nor receive them, nor
11 was I ever assigned a case at that point in
12 time to investigate a suspicious order.

13 Q. All right. So again, in your
14 preparation for this deposition in talking
15 about suspicious order reports and how they
16 were handled, would it be correct to say that
17 the board had no policy or procedure that
18 required any kind of utilization of suspicious
19 order reports, up until 2012 at least?

20 A. I don't know that.

21 Q. Did you find out anything in
22 connection with your investigation to get ready
23 for the deposition to indicate that suspicious
24 order reports were utilized in any way by the
25 board prior to 2012?

1 A. I have no knowledge of it.

2 Q. So help me again. 2012, you
3 became aware of suspicious order reports and my
4 understanding is you're saying that they were
5 -- you say catalogued by year?

6 A. Yes.

7 Q. All right.

8 A. And kept in whatever -- it was a
9 paper format because we were getting them in
10 various faxes, emails, Excel spreadsheets, Word
11 documents. You name it, we were getting them
12 in various forms.

13 Q. All right. And this -- what you
14 just described that you became aware of in
15 2012, how long did that procedure exist?

16 A. I'm not sure when we changed it,
17 but we changed it to -- from the administrative
18 supervisor receiving them to an analyst
19 receiving them and reviewing them.

20 Q. Can you give me an estimated date
21 or time when that happened?

22 A. 13/14.

23 Q. Would it be correct to say that
24 the -- when the administrative person was
25 getting them and putting them in the binder,

1 are you aware of anything else that was done
2 other than receiving them and putting them in
3 the binder prior to 2012?

4 A. I'm sure they were reviewed, but I
5 don't -- I don't have direct knowledge.

6 Q. All right. I'm sorry, prior to
7 2013 or '14 when they started going to the
8 analyst. I mis-asked the question.

9 Same question, I'm just saying up
10 until that time, to your knowledge sitting here
11 today, the only thing that happened to
12 suspicious order reports when they came to the
13 board was the administrative person catalogued
14 them and put them in a notebook by year?

15 A. I think that they were reviewing
16 them, but I don't -- I don't have a direct
17 policy or procedure on how that was done.

18 Q. And you don't know of any action
19 that was taken based upon the review that they
20 may have done?

21 A. No, sir.

22 Q. Now, after 2013/14 when the
23 analysts starting getting them, what changed?

24 A. They were monitoring them for the
25 time being that we had an analyst, and then in

1 '15 and '16, somewhere between 15/16 we started
2 to take all of the format and put them into a
3 digital format, taking all of those paper
4 documents and entering them into an Excel.
5 That way we could search them and look more
6 easily at the data that we had.

7 And after that I believe we
8 maintained three years' worth of records at
9 that time once we got the preservation order.
10 We keep them indefinitely now.

11 Q. All right. Now, during this time
12 where you were getting them and they were
13 reviewing them as you just described and
14 putting them into digital format, my
15 understanding from your earlier testimony was
16 that -- I mean, the report form hasn't changed,
17 right? You haven't added any requirements
18 beyond what we just read?

19 A. No.

20 Q. The report is the same. So it
21 still doesn't contain any of this context that
22 you talked about?

23 A. Correct.

24 Q. So is your standard procedure --
25 other than what you just described and putting

1 them into digital format so they could be
2 searched, have you changed the procedure
3 whereby you contact the wholesale drug
4 distributor and ask questions every time?

5 A. Not every time. We have in the
6 past if it -- if it looks suspicious or if it
7 isn't -- you know, if it raises some type of
8 red flag myself or another supervisor may ask
9 for additional follow-up. And, additionally,
10 we've also had some investigations that have
11 started because of them.

12 Q. All right. First one, you said
13 additional follow-up. By additional
14 follow-up -- well, I hadn't heard anything
15 about an initial follow-up other than the
16 possibility of calling the wholesale drug
17 distributor.

18 A. Yeah, an initial follow-up of why
19 it's suspicious.

20 Q. All right. And that would be
21 before you would initiate any kind of
22 investigation based upon one or more suspicious
23 order reports?

24 A. Yes, sir.

25 Q. All right. What would be the

1 questions that would be asked if you called a
2 wholesale drug distributor?

3 A. Why is it suspicious, did you cut
4 off the -- did you cut off the pharmacy, are
5 you still selling to them, why do you feel --
6 did it deviate from their normal purchasing,
7 was it a large quantity, what made this order
8 suspicious in your system.

9 Q. Have you, yourself, had any such
10 conversations with wholesale drug distributors?

11 A. I believe I have.

12 Q. And this follow-up that you just
13 described, was this beginning to occur in the
14 2014/2016 time frame we were describing where
15 you were doing more with them and putting them
16 into digital form and all of that?

17 A. I think it would have been more --
18 it would have probably been 14/15-ish.

19 Q. Do I understand your testimony
20 correctly that there has not been an instance
21 where an investigation was triggered by a
22 suspicious order report alone, just the number
23 report that came in, you always did follow-up?

24 A. Yeah, not without an initial
25 contact. We're going to call and find out.

1 Q. Okay. As you sit here today, can
2 you tell me of any investigation that was
3 actually initiated based upon a suspicious
4 order report or reports and the follow-up that
5 you did?

6 A. That's confidential.

7 Q. Well, are there any investigations
8 that you did -- well, strike that.

9 I mean, we've tried to go through
10 the documents that have been produced and there
11 are many documents that do talk about the
12 results of investigations that have been made
13 public because something has happened --

14 A. Right.

15 Q. -- there's been some kind of an
16 action taken --

17 A. Yep.

18 Q. -- and have not been able to find
19 any where suspicious orders were mentioned in
20 these reports.

21 So I'll ask the question: Have
22 you done any investigations that resulted from
23 suspicious order reports and their follow-up
24 that resulted in some kind of a public
25 suspension or revocation or a fine or

1 something?

2 A. The investigations themselves are
3 confidential; however, there are current
4 investigations that are going on that have not
5 went through the whole administrative process
6 at this point in time or are still being
7 investigated.

8 Q. And these would be investigations
9 of dispensers?

10 A. Of dispensers and/or wholesalers.

11 Q. When you talk about investigations
12 that were triggered by a suspicious order
13 report follow-up, as you sit here today would
14 those all be post the 2014, '15, '16 time
15 frame?

16 A. I believe the majority would be.

17 Q. And to talk a little bit about,
18 you know, your comment about the numbers, based
19 upon your knowledge gained through your work
20 with the Board of Pharmacy, is it correct that
21 the ordering that is done by dispensers in Ohio
22 as far as the quantity is concerned varies a
23 lot, to use a technical term?

24 A. It really depends on their
25 business model. I mean, a dispenser -- you

1 could have an outpatient pharmacy at Cleveland
2 Clinic verse a mom-and-pop, you know,
3 independent pharmacy, so it varies all over, to
4 independent physicians.

5 Q. So a pharmacy, for example, your
6 mom-and-pop, if one of the patients that
7 customarily came there got cancer or was put in
8 hospice and was getting those medications, that
9 could make a significant change in the amount
10 of opioids that they would be ordering?

11 A. It could be, absolutely.

12 Q. So depending -- and would I be
13 correct that the ordering pattern of a
14 particular pharmacy or dispenser is going to
15 depend on the prescribing -- the prescribers,
16 whoever they are, and the patients, and what's
17 going on with those prescribers and patients at
18 any given time?

19 A. Yes, sir.

20 Q. And it's going to go up and down
21 and change?

22 A. (Witness nodded head up and down.)

23 Q. You have to speak.

24 A. Yes, sir. Sorry.

25 Q. You don't have to say sir, but you

1 need to speak.

2 Am I correct that the regulation
3 again I mentioned or asked you, it's a
4 reporting requirement?

5 A. Yes, sir.

6 Q. Does the Board of Pharmacy expect
7 or anticipate that suspicious orders that are
8 reported will not be shipped to the pharmacy?

9 A. No, our expectation is that they
10 do their due diligence. If a computer spits
11 out a number and says, hey, this is a
12 suspicious order, the hope is that they're
13 going to follow up with that, do their due
14 diligence, check with the customer, try to find
15 out, such as the recently -- like you
16 explained, new prescriber in the area or a new
17 practice in the area, whatever it may be, but
18 to do their due diligence on them, on those
19 particular customers; and if they feel that it
20 is not legitimate, that they don't ship it.

21 Q. If a wholesale drug distributor
22 called you up and did some follow-up, said,
23 hey, Board of Pharmacy, we're looking at
24 dispenser X in Akron, Ohio and we sent you a
25 suspicious order report a couple months ago

1 about them, would you give us an OARRS report
2 on that dispenser so we can see what their
3 dispensing pattern is for the last two or three
4 months, would you do that?

5 A. No, but we could based upon --

6 Q. We --

7 A. We, the Board of Pharmacy, could
8 based upon your phone call and your
9 information.

10 Q. But wholesale drug distributors
11 wouldn't have access to any of that
12 information?

13 A. Not the OARRS.

14 THE VIDEOGRAPHER: I need to stop.

15 MR. EMCH: Oh, okay.

16 THE VIDEOGRAPHER: We're off the
17 record.

18 (Recess taken.)

19 THE VIDEOGRAPHER: We're on the
20 record.

21 (Thereupon, Defendants' Exhibit
22 Number 20, Ohio Automated Rx Reporting System
23 2017 Annual Report, was marked for purposes of
24 identification.)

25 BY MR. EMCH:

1 Q. You've got in front of you Exhibit
2 Number 20, which is, I believe, the 2017 OARRS
3 report?

4 A. Yes, sir.

5 Q. And the Board of Pharmacy's fiscal
6 year runs from the middle of -- from July to
7 July; is that right?

8 A. Yes, sir.

9 Q. And I've seen both OARRS reports
10 and the annual reports for the board through
11 2017 or what they call the 2017 fiscal year.

12 Is there a 2018 report yet; do you
13 know? I didn't look at your website.

14 A. I don't know.

15 Q. But the OARRS report and the
16 annual report are normally entered at the same
17 time or prepared and issued at the same time,
18 if you know?

19 A. I believe so.

20 Q. This Exhibit Number 20, have you
21 seen that?

22 A. I've glanced over it just off of
23 our website.

24 Q. Are you able, do you think, to
25 answer some questions about it?

1 A. I can try.

2 Q. Okay. Go to -- I'm skipping a
3 lot. Go to Section 1. Title is Section 1,
4 opioids dispensed to Ohio patients, right?

5 A. Yes, sir.

6 Q. Okay. And I'll ask -- some of
7 these questions will probably be silly, but,
8 you know, that goes with the territory
9 occasionally. Opioids dispensed to Ohio
10 patients, so that means opioids not that were
11 stolen or had something else, some other way
12 they got into somebody's hands; they mean
13 through the OARRS program what you have tracked
14 and has been recorded as being dispensed by
15 registered, licensed dispensers in the State of
16 Ohio?

17 A. Yes, sir.

18 Q. And prescribed by registered
19 licensed prescribers in Ohio?

20 A. Yes, sir.

21 Q. Now, you talked a little bit
22 earlier about this, but just to be clear, the
23 only entities who have a legal and professional
24 obligation to prescribe and dispense
25 prescriptions only for legitimate medical

1 purpose in the usual course of professional
2 practice are prescribers, mostly doctors, and
3 pharmacists; is that right?

4 A. I believe so.

5 Q. Is it also true that it is only
6 those -- those two entities, the prescriber who
7 is treating the patient and the pharmacist who
8 is asked to fill the prescription, who can make
9 and are legally obligated to make a
10 determination that the prescription is for a
11 legitimate medical purpose?

12 A. Yes, sir.

13 Q. And there isn't anybody else in
14 the system that can prospectively make that
15 decision; it's made on the spot by the doctor
16 prescriber and by the dispenser, the
17 pharmacist, correct?

18 A. Yes, sir.

19 Q. Now, to go to the Section 1 that
20 we were looking at, this chart, number 1 that's
21 there, goes back to 2011, and would I be
22 correct that if we move backwards in a previous
23 OARRS report, a similar chart exists in those
24 reports for 2010, 2009?

25 A. I would assume so.

1 Q. So this one goes from 2011 to 2017
2 and the top chart number 1 is showing solid
3 doses dispensed to Ohio patients by year, and
4 these would be opioid solid doses defined as
5 tablets, capsules and patches. That's at the
6 bottom of the page under your finger.

7 A. Yes, sir.

8 Q. Now, all opioids are included in
9 these numbers --

10 A. Okay.

11 Q. -- correct?

12 A. Yes.

13 Q. Do you have a place that breaks
14 them down by particular opioids?

15 A. I'm sure that OARRS does. I don't
16 have it personally.

17 Q. Do you know how many different
18 opioids are tracked in OARRS?

19 A. All of them.

20 Q. But do you know how many of them
21 there are?

22 A. Oh, I do not.

23 Q. Can you give me an estimate?

24 A. I cannot.

25 Q. More than three or four?

1 A. Yes.

2 Q. A lot more than three or four?

3 A. Yes.

4 Q. But these charts don't break it
5 down, the statistics don't break it down to
6 that level; it's everything included?

7 A. Yeah, in Section 1.

8 Q. And these are dosage units,
9 correct?

10 A. Yes.

11 Q. So these charts don't tell you
12 anything about the actual amount in milligrams
13 or MEDs, this chart doesn't --

14 A. It does not.

15 Q. -- that are involved in any of the
16 dosage units?

17 A. It does not talk about MED at all.

18 Q. So they could be 5 milligram with
19 500 acetaminophen or 10 milligram or whatever
20 the largest pill or dosage is, correct?

21 A. Yes, sir.

22 Q. Now, chart number 2 is
23 prescriptions dispensed to Ohio patients in
24 each year in millions, correct?

25 A. Yes, opioid prescriptions.

1 Q. Opioid prescriptions?

2 A. Yes, sir.

3 Q. Do you know what the population of
4 Ohio was in 2010 or is today?

5 A. I don't know. It's in the
6 millions.

7 Q. Okay. And chart number 1 shows
8 that the total number of dosage units and the
9 total number of prescriptions peaked in 2012,
10 agreed?

11 A. Yes, sir.

12 Q. And, generally speaking, the two
13 lines, the solid doses dispensed in Ohio and
14 the prescription numbers, I'll say correlate,
15 if not correspond; more prescriptions, more
16 doses?

17 A. Yes, sir.

18 Q. You're aware of Ohio's enactment
19 of prescribing guidelines? You know what I
20 mean by that?

21 A. Yes, sir.

22 Q. And Ohio has done that, I think,
23 three times now; am I right?

24 A. Yes, there's emergency room
25 guidelines, there's acute pain, yes.

1 Q. And the emergency room was in
2 2012?

3 A. I believe so.

4 Q. And the guidelines for chronic
5 pain were in 2013 and the guidelines for acute
6 pain in 2016?

7 A. Yes, sir.

8 Q. And then further restrictions
9 placed upon prescribing in 2017?

10 A. Okay.

11 Q. And I'll represent to you that
12 those are right. They sound right to you?

13 A. They sound correct to me.

14 Q. And these charts that we're
15 looking at have been decreasing since 2012,
16 right?

17 A. Yes, sir.

18 Q. Do you think the prescribing
19 guidelines have had an impact on that?

20 A. I do.

21 Q. Were there, to your knowledge,
22 prescribing guidelines for the prescribing of
23 opioids in Ohio prior to May of 2012?

24 A. Not to my knowledge.

25 Q. Now, if you go to the next page,

1 it has table 1, opioids dispensed by Ohio
2 patients -- or to Ohio patients by year, and
3 that runs 2010 to 2017. Do you see that?

4 A. Yes, sir.

5 Q. Table number 1.

6 Now, back to a question that two
7 of my colleagues were asking you or you were
8 testifying about earlier, which is the reports
9 that were generated about opioid deaths --
10 well, overdose deaths, not opioid deaths,
11 overdose deaths in Ohio and the lookback at
12 OARRS reports --

13 A. Yes, sir.

14 Q. -- for those persons who are
15 deceased, was that -- was that done for all of
16 the overdose deaths in Ohio?

17 A. It was all the opioid-related
18 overdose deaths, unintentional overdose deaths.

19 Q. I'm sorry, I misstated after I
20 clarified myself. Was the OARRS check done for
21 all drug overdose deaths in Ohio?

22 A. I believe it was done for all
23 opioid overdose deaths in Ohio.

24 Q. Did you do it on your own
25 initiative or were you asked by somebody to do

1 it?

2 A. I can't recall. I think it was
3 more of a collaborative effort with us and the
4 Health Department.

5 Q. But it was for all of Ohio?

6 A. Yes, sir.

7 Q. What year or years did you cover?

8 A. We only recently in the last three
9 or four years started getting the data and from
10 health is where we were getting the overdose --
11 unintentional overdose death data. And their
12 data is behind several months, so I think we've
13 only done it for three years now where we've
14 compared the information.

15 Q. And I believe you indicated that
16 -- and you clarified that what you were looking
17 at were opioid-related deaths; is that your
18 description?

19 A. Yes.

20 Q. Opioid-related deaths, overdose
21 deaths? Opioid-related overdose deaths?

22 A. Let's throw unintentional overdose
23 deaths in there.

24 Q. So you excluded suicides?

25 A. I didn't personally exclude them,

1 but that would be one that would be -- I would
2 assume was excluded from there.

3 Q. And as I understand what you
4 looked for and what your data reflects is when
5 we went -- when we looked at any given
6 unintentional opioid-related death, we checked
7 the OARRS records back for how long?

8 A. As far as the OARRS record went
9 back.

10 Q. So you didn't limit it to like
11 eighteen months or two years, you went back as
12 far as you could go back?

13 A. I believe that that's what they
14 did.

15 Q. All right. And then you simply
16 recorded whether or not there was one or more
17 prescription opioid on that record?

18 A. Yes.

19 Q. And when you said 70 or 80
20 percent, that means literally that, that there
21 was one or more opioid prescription on that
22 several years of record that you look for --
23 looked at for these unintentional
24 opioid-related deaths?

25 A. Yes, sir.

1 Q. Do you know -- and you said 70 or
2 80 percent of that particular population that
3 you were looking at. Do you know how many --
4 what percent -- do you know what percentage of
5 the adult population in Ohio has an opioid
6 prescription in their OARRS history?

7 A. I do not know.

8 Q. If we look at table 1, and the
9 number of patients that are indicated in that
10 number of patients column. Do you see that?

11 A. Yes, sir.

12 Q. Does that indicate -- like for
13 2010 it says 2,733,066 patients and then the
14 next year it's 2,761,707 patients. Do you know
15 if those are the same patients or were there
16 new and different patients in each of those
17 years?

18 A. I don't know. I'm assuming there
19 would be new patients.

20 Q. So if we took, say, a two-year
21 time or a three-year time and those numbers
22 that are in there and we just looked at those
23 -- say we looked at 2015, '16 and '17, 2.6,
24 2.3, 1.9 million, and we pulled out all of the
25 different patients, we would come up with a

1 higher number than any of those three numbers,
2 right?

3 A. So you want to combine all three
4 of them and pull out --

5 Q. I just want to look through them
6 and pull out how many different patients are
7 represented in those three years. How many
8 different patients got opioid prescriptions on
9 their OARRS record for those three years?

10 MR. WAKLEY: I'm going to object
11 to this. Mr. Griffin has not been designated
12 as any kind of representative as to OARRS data.
13 This is an OARRS report. Chad Garner was the
14 individual who would have participated in this.
15 This is not the correct witness to ask those
16 questions.

17 THE WITNESS: Do I still need to
18 answer it?

19 BY MR. EMCH:

20 Q. Well, you can try.

21 A. I would assume, but I don't --
22 don't know for sure.

23 Q. Okay. But in the event you
24 haven't done -- or you don't know of any
25 studies that have been done or any reports that

1 have been run by the Board of Pharmacy to try
2 to compare different populations with the
3 population of unintentional opioid-related
4 overdose deaths?

5 A. I don't quite understand your
6 question.

7 Q. What percentage of the entire
8 adult population of Ohio -- as I asked you
9 before, for comparison purposes, what
10 percentage of them have an opioid prescription?

11 A. I don't know.

12 Q. You're not aware of any --

13 A. I'm not aware of any.

14 Q. Do you see on table 1 again where
15 it says average daily MED per prescription and
16 average quantity per prescription? Do you see
17 those two columns?

18 A. I do.

19 Q. Do you, yourself, have any
20 information about -- well, strike that.

21 I notice that those numbers, even
22 though the number of prescriptions written and
23 the number of patients, to some degree, has
24 diminished in general over time, the average
25 quantity per prescription and the average MED

1 per prescription has stayed fairly close.

2 Do you see that? It hasn't
3 changed all that much?

4 A. Yes, sir.

5 Q. Do you agree with me that that
6 would indicate that the mix of prescriptions,
7 the mix of dosages, high dosages, a lot of MEDs
8 per day, has stayed relatively constant even
9 though the number of prescriptions overall and
10 the number of patients, to a lesser degree,
11 have diminished?

12 Do you understand my question?

13 MR. WAKLEY: Again, I object.

14 THE WITNESS: I don't.

15 MR. WAKLEY: This is outside this
16 witness' scope of knowledge.

17 BY MR. EMCH:

18 Q. Do you have any idea yourself or
19 any knowledge yourself, based upon your
20 familiarity with OARRS and dispensers and the
21 board, what kind of average daily MED per
22 prescription or per day would be utilized by an
23 end-of-life patient or a cancer patient or a
24 hospice patient?

25 MR. WAKLEY: Again, it's outside

1 this witness' scope of knowledge.

2 BY MR. EMCH:

3 Q. You were asked some questions
4 about -- or a question about the DEA's quota
5 program?

6 A. Yes, sir.

7 Q. And you know what that is?

8 A. I do.

9 Q. But the Board of Pharmacy has
10 never been involved in that program?

11 A. Not to my knowledge.

12 Q. Has the Ohio Board of Pharmacy
13 ever, to your knowledge, considered
14 implementing some kind of quota program itself?

15 A. Not to my knowledge.

16 Q. Has the Ohio Board of Pharmacy
17 ever considered setting forth some kind of a
18 restriction on the number of dosage units that
19 could be dispensed in a particular geographic
20 area based on the population of that area?

21 A. Not to my knowledge.

22 Q. Have you ever heard that subject
23 brought up? Do you understand what my question
24 is? Saying that there are a certain number of
25 dosage units that are coming into a particular

1 area --

2 A. Right.

3 Q. -- like Columbus. It's X number.
4 We think that might be a lot, too much, so why
5 don't we limit it, why don't we say
6 prospectively, while the population of Columbus
7 is 600,000, and so you can only dispense, pick
8 your number, based on that population?

9 A. I have not engaged in any
10 conversations, nor do I recall any types of
11 conversations like that.

12 Q. You couldn't do that, could you?
13 You couldn't make a prospective limit based on
14 population?

15 A. I don't see how you could.

16 MR. EMCH: I'm going to pass, with
17 the understanding that I am going to look
18 through my notes, too, just because we want to
19 stick with the schedule here. So I might come
20 back briefly.

21 * * *

22 CROSS-EXAMINATION

23 BY MS. RANJAN:

24 Q. Good afternoon, Mr. Griffin.

25 A. Hello.

1 Q. My name is Brandy Ranjan. I
2 represent Wal-Mart here today. Hopefully I can
3 keep this brief because I know we're running
4 close to time and it's been a long day, so --

5 A. Thank you.

6 Q. Sure.

7 Earlier during Ms. Browne's
8 questioning you were asked about the variety of
9 ways in which complaints might reach the board
10 and become investigated. Do you recall that
11 testimony?

12 A. Yes, ma'am.

13 Q. And I think that you testified to
14 a number of sources. I think you said that the
15 top two sources for those complaints were the
16 public, that was the first?

17 A. Yes, ma'am.

18 Q. And the second was, you said, loss
19 prevention within the industry?

20 A. Yes, ma'am.

21 Q. Can you explain to me what you
22 mean by that?

23 A. Sure. We get and we work with
24 regularly loss prevention on employees from CV
25 -- different pharmacy chains and corporations

1 that report to us potential theft and loss on a
2 regular basis. The majority of these
3 diversions are small quantities that are
4 swiped. It may not just be loss prevention
5 from a retail chain, it may be a security
6 person or a compliance person at a hospital or
7 at a clinic type of setting where they're
8 calling us to report small doses of theft and
9 loss that we investigate, and again, most of
10 them are small quantities.

11 Q. Okay. So just to make sure I
12 understand, so it could be a pharmacy or a
13 hospital or a doctor's office that's reporting
14 to you that they've either lost a small amount
15 of some controlled substance; is that right?

16 A. They believe they've lost. I
17 mean, we do initial notification immediately
18 and then we start the investigation from there.

19 Q. I see. But it could be as a
20 result of either a loss or a theft of the drug?

21 A. Yes, ma'am.

22 Q. And that's an example of the
23 industry cooperating with the board to try to
24 address potential illegal activity; is that
25 right?

1 A. Yes, ma'am.

2 Q. And in your experience is that
3 kind of cooperation and collaboration within
4 the industry fairly common?

5 A. I believe it is here in the State
6 of Ohio. We've had round tables strictly with
7 loss prevention folks and invited them in for
8 discussions and different things like that, so
9 I would say yes.

10 Q. And one of the sources of the
11 complaints that you mentioned was that
12 complaints might come in from other law
13 enforcement agencies; is that right?

14 A. Yes, ma'am.

15 Q. And that, I assume, would include
16 county sheriff's offices, correct?

17 A. Yes, ma'am.

18 Q. And I think that we talked about
19 some numbers of complaints that you received
20 for Cuyahoga and Summit County. I believe you
21 said you received 700 complaints for Cuyahoga
22 County over the last five years, right?

23 A. It's just over 700.

24 Q. Okay. And that's the total number
25 of complaints within that jurisdiction that you

1 received from all sources?

2 A. Correct.

3 Q. Do you have any idea how many of
4 those would have been referrals from the
5 Cuyahoga County sheriff's office?

6 A. I have no idea.

7 Q. Or the Akron -- I'm sorry, the
8 Cleveland police department?

9 A. We've worked in conjunction with
10 Cleveland police department, so there may be
11 some from them.

12 Q. Do you have a general sense? Is
13 it, you know, 10 percent, half?

14 A. I couldn't -- I would say it's a
15 low percentage, but I couldn't put a number on
16 it.

17 Q. Okay. Probably less than 25
18 percent?

19 A. Yes.

20 Q. Probably less than 15 percent?

21 A. Yes.

22 Q. Probably less than 10 percent?

23 A. I don't know there.

24 Q. Okay. That's fair. I'm just
25 trying to get a general sense.

1 And then the same question for the
2 123 complaints that you received for the Summit
3 County jurisdiction, that was from all sources
4 over the last five years?

5 A. It was a little over -- I think it
6 was 231 complaints.

7 Q. I'm sorry, I had the number wrong.
8 231 complaints. That was from all sources over
9 the last five years?

10 A. Yes, ma'am.

11 Q. And would the breakdown there in
12 terms of complaints that you were receiving
13 from Summit County sheriff's office and the
14 Akron police department be roughly the same as
15 in Cuyahoga County?

16 A. Maybe a little less, just because
17 Cuyahoga County has more population, we've had
18 more cases there. Probably less.

19 Q. Okay. So there could you say less
20 than 15 percent? That was sort of the gauge we
21 were going by before.

22 A. Yeah, less than 15.

23 Q. Less than 10 percent?

24 A. Most likely.

25 Q. Changing gears, Mr. Griffin, you

1 would agree with me that pharmacists and
2 pharmacies don't practice medicine, right?

3 A. They do not practice medicine.
4 They practice pharmacy.

5 Q. Pharmacists are not trained as
6 physicians?

7 A. They are not.

8 Q. And they cannot diagnose patients?

9 A. I think it gets into a scope
10 question between pharmacists and physicians.
11 There are collaborative agreements that
12 physicians can enter with pharmacists to help
13 change med dosing and different things like
14 that, but typically they are not diagnosing
15 disease states.

16 Q. In the typical exchange that we
17 think of where a patient walks into a pharmacy
18 and presents a prescription and has that
19 prescription filled, the pharmacist is not
20 making a diagnosis of that patient; is that
21 right?

22 A. Correct.

23 Q. And in Ohio pharmacists are also
24 not licensed to prescribe medications?

25 A. They're not licensed to prescribe

1 medications; however, again, with some consult
2 agreements under certain disease states I
3 believe that they can add medications to a
4 formulary for a patient for certain disease
5 states such as diabetes.

6 Q. Okay. And those would be sort of
7 the edge case type of situations, right?

8 A. What do you --

9 Q. So that would be an unusual
10 circumstance, something that doesn't happen in
11 your everyday exchange, again where the patient
12 is walking in and having their --

13 A. Right.

14 Q. -- prescription filled at a
15 pharmacy, right?

16 A. Right.

17 Q. And again, speaking of that
18 typical exchange between a pharmacist and a
19 patient where a patient walks into a pharmacist
20 -- pharmacy and presents a prescription, the
21 pharmacist doesn't have access to the patient's
22 medical records in that situation, do they?

23 A. The majority of the time, no.
24 However, there are pharmacies that are within
25 institutions where a pharmacist may have access

1 to -- where a retail pharmacy has access to the
2 patient files.

3 Q. Like that would happen in a
4 hospital, for instance?

5 A. A hospital, large clinic, oncology
6 clinics that have their own pharmacies in them,
7 medical facilities, some of them, they use the
8 same, or would have access to that -- the
9 medical records.

10 Q. To your knowledge do pharmacists
11 at national retail chains like Wal-Mart, CVS,
12 Rite Aid, do they typically have access to a
13 patient's medical records when they're
14 dispensing medication?

15 A. No, ma'am.

16 Q. Pharmacists do have access to
17 OARRS now in Ohio, right?

18 A. Yes, ma'am.

19 Q. But even OARRS also has a limited
20 set of information; would you agree with that?

21 A. Yes, ma'am.

22 Q. For instance, up until -- until
23 recently, OARRS didn't include a patient's
24 diagnosis?

25 A. Correct.

1 Q. When was that added?

2 A. Recently. I think it was first
3 discussed -- I'm trying to think if it went
4 into effect in '17 or '18, but recently we just
5 started collecting the diagnosis codes on
6 prescriptions.

7 Q. And OARRS doesn't describe a
8 physician's treatment plan?

9 A. It doesn't describe their
10 treatment plan?

11 Q. Correct.

12 A. No.

13 Q. And it doesn't have the
14 physician's reasoning for prescribing a drug?

15 A. No.

16 Q. It doesn't disclose what
17 conversations the physician may have had with a
18 patient about a particular course of treatment?

19 A. No.

20 Q. In other words, it doesn't paint
21 the whole picture of the patient's medical
22 condition, correct?

23 A. Correct.

24 Q. Would you agree with me,
25 Mr. Griffin, that there may be valid reasons

1 why a patient would have multiple -- would have
2 prescriptions from multiple doctors?

3 A. Yes, ma'am.

4 Q. And would you agree with me that
5 there may be valid reasons for having
6 prescriptions filled in multiple locations?

7 A. There could be, yes.

8 Q. For instance, it could just be a
9 matter of convenience, right?

10 A. Yes, ma'am.

11 Q. Or possibly insurance coverage?

12 A. Yes, ma'am.

13 Q. There are some insurers that
14 require patients to have certain medications
15 filled by certain dispensers?

16 A. Yes, ma'am.

17 Q. And that circumstance in and of
18 itself, having a prescription filled in
19 multiple locations, does not necessarily
20 indicate diversion or illegal activity, right?

21 A. It does not.

22 Q. And having prescriptions from
23 multiple doctors does not necessarily indicate
24 diversion or illegal activity?

25 A. It does not.

1 Q. Ohio law requires pharmacists to
2 exercise professional judgment when dispensing
3 medications, right?

4 A. Yes, ma'am.

5 Q. And do you agree with me that the
6 exercise of that professional judgment is a
7 subjective exercise?

8 A. It can be; however, there are some
9 requirements that a pharmacist must do before
10 dispensing medication.

11 Q. We talked about some of those
12 earlier, right?

13 A. Yes, ma'am.

14 Q. The pharmacist has to do a
15 prospective Drug Utilization Review; is that
16 right?

17 A. Yes, ma'am.

18 Q. And there are some circumstances
19 in which a pharmacist must check OARRS?

20 A. Yes, ma'am.

21 Q. And then after evaluating all of
22 that information that's available to the
23 pharmacist, the pharmacist exercises his or her
24 judgment about whether or not the medication
25 should be dispensed, right?

1 A. Yes, ma'am, or within consultation
2 with the prescriber who wrote the prescription.

3 Q. Right. That's one step that a
4 pharmacist might take to resolve a potential
5 red flag that the pharmacist sees, right?

6 A. Yes, ma'am.

7 Q. The pharmacist could consult with
8 the doctor?

9 A. Yes, ma'am.

10 Q. So you agree with me that
11 pharmacists can take steps to resolve any red
12 flags that a particular prescription might
13 present?

14 A. Yes.

15 Q. And ultimately the duty to
16 evaluate whether or not a prescription should
17 be dispensed rests with the pharmacist,
18 correct?

19 A. Yes, ma'am.

20 Q. Not the pharmacy?

21 A. Correct.

22 Q. And not the pharmacist's employer?

23 A. Correct.

24 Q. Each patient's circumstances are
25 unique and have to be evaluated independently,

1 right?

2 A. Yes, ma'am.

3 Q. Do you have Exhibit 16 in front of
4 you still? It was one of the Ohio State Board
5 of Pharmacy newsletters from November 2014.

6 A. Yep. November of 2014?

7 Q. Yes.

8 A. Yes, ma'am.

9 Q. It should be labeled Exhibit 16.

10 A. Yes, ma'am.

11 Q. I would like to look at the
12 paragraph that was reviewed earlier on the
13 first page. It's the big huge paragraph in the
14 bottom right-hand corner with the numbered
15 bullets. Do you see that?

16 A. Yes, ma'am.

17 Q. When we looked at this earlier we
18 discussed how this newsletter was -- was
19 informing recipients of the newsletter about
20 some new regulations that have been put in
21 place; is that right?

22 A. Yes, ma'am.

23 Q. And those regulations were the
24 ones that required prescribers to begin
25 checking OARRS in certain circumstances?

1 A. Yes, ma'am.

2 Q. And I would like to read the
3 sentence that is towards the middle of that
4 paragraph above the bullet point list. It
5 begins while there are new mandatory
6 requirements. Do you see that?

7 A. Yes, ma'am.

8 Q. It says while there are new
9 mandatory requirements for prescribers to check
10 OARRS, pharmacists should also be aware that
11 they have a corresponding responsibility to
12 check the system, and it cites a portion of the
13 administrative code. Do you see that?

14 A. Yes, ma'am.

15 Q. And it says that that section of
16 the administrative code, which is 4729-5-20,
17 requires a check of OARRS in any of the
18 following instances.

19 Did I read that properly?

20 A. Yes, ma'am.

21 Q. And it lists a number of
22 circumstances in which a pharmacist has a
23 corresponding duty to check OARRS; is that
24 right?

25 A. Yes, ma'am.

1 Q. And if I understand your testimony
2 from earlier, I think that you would agree with
3 me that just because one of these circumstances
4 is present, doesn't necessarily indicate that
5 diversion is happening; is that correct?

6 A. Yes, ma'am.

7 Q. So, for instance, the first bullet
8 point there, receiving reported drugs from
9 multiple prescribers, we talked earlier that
10 doesn't necessarily indicate that there would
11 be diversion happening, right?

12 A. Yes, ma'am.

13 Q. This is just a list of the
14 circumstances in which a pharmacist should
15 consider checking OARRS, correct?

16 A. Yes, ma'am.

17 Q. And then again, at the bottom it
18 says, in conclusion, the pharmacist, not an
19 employer, supervisor or fellow employee, is the
20 one held accountable for making an independent
21 judgment to ensure the prescription - and then
22 it continues on the back, the very last page -
23 presented at the pharmacy is legitimate.

24 Did I read that properly?

25 A. Yes, ma'am.

1 Q. And that's what we talked about
2 earlier, about how it's the pharmacist, and not
3 their employer, who has the duty to make that
4 judgment about whether a medication should be
5 dispensed, right?

6 A. Yes, ma'am.

7 MS. RANJAN: I, like the others,
8 have very disorganized notes at this point, so
9 I will reserve the right to ask a couple of
10 follow-ups, but I think I may be done, so --

11 * * *

12 CROSS-EXAMINATION

13 BY MR. RUIZ:

14 Q. Hi, Mr. Griffin.

15 A. Hello.

16 Q. Thank you for your time today.

17 My name is Anthony Ruiz and I
18 represent CVS Indiana, LLC and CVS Rx Services,
19 Inc. Do you recognize those two entities as
20 wholesale drug distributors?

21 A. They are -- CVS is a corporation.
22 I believe they have their own in-house
23 wholesale where they distribute to their
24 pharmacies, but their pharmacies are drug --
25 are licensed as terminal drug distributors.

1 Q. Right, and I'm not asking about
2 the terminal drug distributors that are the
3 pharmacies, but do you recognize the two
4 entities that I represent, CVS Indiana, LLC and
5 CVS Rx Services, Inc., as not terminal drug
6 distributors, but actually wholesale -- they
7 have wholesale drug distributor licenses?

8 A. I would believe so, if that's what
9 you're telling me. I know that CVS has its own
10 internal wholesale. I don't know the names of
11 them specifically by Inc. and LLCs.

12 Q. Okay. Earlier today, in
13 connection with some discussions about
14 suspicious order reports, you mentioned an
15 expectation that distributors conduct due
16 diligence in connection with those reports.
17 Do you recall that?

18 A. Yes, ma'am -- or yes, sir, sorry.

19 Q. And you recall that we looked at
20 -- I believe it was Exhibit 15 which has the
21 suspicious order standard --

22 A. Yes.

23 Q. -- that's under H(1)(e). Do you
24 recall that?

25 A. Yes.

1 Q. The text of that rule doesn't say
2 anything about due diligence; is that right?

3 A. It does not.

4 Q. Is that expectation related to due
5 diligence, is that a requirement?

6 A. It's not required by the rule;
7 however, it would be an expectation to ensure
8 drug security and control.

9 Q. And has that expectation been
10 codified in any way in the laws or the rules by
11 BOP?

12 A. No, sir.

13 Q. Has it been -- strike that.

14 If we could look at Exhibit 17 --

15 A. Yes, sir.

16 Q. -- and that's the May 2010 BOP
17 newsletter.

18 A. Yes, sir.

19 Q. If you look at the last page.

20 Do you remember you were asked
21 some questions about this second to last
22 heading that reads corresponding
23 responsibilities needed more than ever?

24 A. Yes, sir.

25 Q. If you look at the last paragraph

1 in that section, the first sentence, it says,
2 having said that, please remember that there
3 are legitimate pain specialists and legitimate
4 pain patients out there. Legitimate patients
5 should have their prescriptions filled in a
6 timely fashion and without harassment.

7 Do you agree with that statement?

8 A. I would, but hold on. Can you
9 point that out again?

10 Q. I'm sorry. So that's the last
11 paragraph of that section.

12 A. Okay.

13 Q. So, first of all, go ahead and
14 read it to yourself --

15 A. Thank you.

16 Q. -- and let me know if I read any
17 of that incorrectly.

18 A. I would agree with that statement.

19 Q. You agree that it's important for
20 people in pain to have access to the medication
21 that a doctor has prescribed for them, right?

22 A. Yes, sir.

23 Q. Are you aware of BOP revoking any
24 CVS wholesale distributor license?

25 A. No.

1 Q. Are you aware of BOP suspending
2 any CVS wholesale distributor license?

3 A. No.

4 MR. RUIZ: That's all I have.
5 Anybody else?

6 MS. BROWNE: I don't have
7 anything.

8 MR. WAKLEY: If you're all done, I
9 have a few clean-up questions I just want to go
10 over with him.

11 MS. BROWNE: Do you need a break
12 first or --

13 MR. WAKLEY: No, I'm good. Let's
14 get this done.

15 DIRECT EXAMINATION

16 BY MR. WAKLEY:

17 Q. Good evening, Mr. Griffin.

18 A. Good evening.

19 Q. In your experience as both a
20 compliance agent up through to your current
21 job, what is the most common type of diversion
22 that you've seen while working at the Board of
23 Pharmacy?

24 A. Small quantity thefts.

25 Q. What percentage of diversion cases

1 overall would you say do not require access to
2 the OARRS database at all?

3 A. A majority of them don't. If we
4 have a -- a theft at a hospital, retail
5 location or a doctor's office, there may never
6 be a need to access OARRS at all.

7 Q. In your experience can the board
8 take action against a licensee solely based on
9 an OARRS check?

10 A. No.

11 Q. Why not?

12 A. Because the information has to be
13 verified and the original documentation
14 collected as evidence.

15 Q. When you say the original
16 documentation, what do you mean, the original
17 documentation?

18 A. Such as the original prescription.
19 Obviously, as I spoke earlier, OARRS can have
20 incorrect data and -- because it is entered via
21 humans and there could be errors and mistakes.
22 And so you want to verify the information that
23 is in OARRS, so you would collect the original
24 documentation or copies of the original
25 documentation.

1 Q. Have you been involved in any
2 disciplinary cases taken by the board against
3 any licensee?

4 A. Yes.

5 Q. In your experience, or are you
6 aware, are OARRS reports allowed to be used in
7 those contexts?

8 A. We do not use OARRS --

9 MR. RUIZ: Objection. Form.

10 THE WITNESS: Sorry. We do not
11 use OARRS reports in those contexts.

12 BY MR. WAKLEY:

13 Q. Why not?

14 A. Because the information is not --
15 it's not as reliable as the original document.

16 Q. Are you aware of any legal
17 requirements that keep OARRS reports or
18 information confidential?

19 A. Yes, there's statutes of laws that
20 protect the OARRS information.

21 MR. WAKLEY: I have no further
22 questions. Thank you.

23 MS. BROWNE: Okay. I think we're
24 done.

25 THE WITNESS: Are we sure?

1 THE VIDEOGRAPHER: We're off the
2 record.

3 (Thereupon, signature was not
4 waived.)

5 (Thereupon, the deposition
6 concluded at 5:21 p.m.)

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1 STATE OF OHIO)

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2 COUNTY OF MONTGOMERY) SS: CERTIFICATE

3 I, Christine Gallagher, a Notary
4 Public within and for the State of Ohio, duly
5 commissioned and qualified,

6 DO HEREBY CERTIFY that the
7 above-named ERIC A. GRIFFIN, was by me first duly
8 sworn to testify the truth, the whole truth and
9 nothing but the truth.

10 Said testimony was reduced to
11 writing by me stenographically in the presence
12 of the witness and thereafter reduced to
13 typewriting.

14 I FURTHER CERTIFY that I am not a
15 relative or Attorney of either party, in any
16 manner interested in the event of this action,
17 nor am I, or the court reporting firm with which
18 I am affiliated, under a contract as defined in
19 Civil Rule 28(D).

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Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

January 28, 2019

To: James T. Wakley

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3194811

Witness: Eric A. Griffin Deposition Date: 1/23/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3194811

CASE NAME: In Re: National Prescription Opiate Litigation v.

DATE OF DEPOSITION: 1/23/2019

WITNESS' NAME: Eric A. Griffin

In accordance with the Rules of Civil
Procedure, I have read the entire transcript of
my testimony or it has been read to me.

I have made no changes to the testimony
as transcribed by the court reporter.

Date Eric A. Griffin

Sworn to and subscribed before me, a
Notary Public in and for the State and County,
the referenced witness did personally appear
and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn
Statement; and
Their execution of this Statement is of
their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3194811

CASE NAME: In Re: National Prescription Opiate Litigation v.

DATE OF DEPOSITION: 1/23/2019

WITNESS' NAME: Eric A. Griffin

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

Date

Eric A. Griffin

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

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ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 1/23/2019

PAGE/LINE(S) / CHANGE /REASON

Date Eric A. Griffin
SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20____ .

Notary Public

Commission Expiration Date

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF SEPTEMBER 1, 2016. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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